

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,321,698.26	ADJUSTMENTS	35,937.45
COVERED CHARGES	5,273,747.09	CONTRACTUAL ALLOW	3,016,141.03
NON-COVERD CHARGES	47,951.17	TOTAL MEDICAID LIAB	2,257,606.06
		LESS: COB	11,973.88
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,245,632.18

TOTAL NUMBER OF ADMISSIONS 346

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	841		0	438,921.00		54.00
ROUTINE NURSERY	119		0	55,499.00		3,400.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	960		0	494,420.00		3,454.00
SPECIAL CARE SERVICES						
CCU	128		0	154,362.00		0.00
ICU	98		0	66,058.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	226		0	220,420.00		0.00
TOTAL ACCOMODATIONS	1,186		0	714,840.00		3,454.00

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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

PHOEBE SUMTER MEDICAL CENTER
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 AMERICUS,GA 31719-8645

PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,057,390.10	583.92	OTHER LAB	11,637.09	0.00
MED/SURG SUPPLY	598,163.55	474.55	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	744,868.38	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	84,304.41	0.00	OTHER THERAPEUTIC SVC	0.00	1,468.56
CT SCAN	181,111.85	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	61,327.36	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	30,990.48	0.00	MRI SERVICES	33,050.07	0.00
IV THERAPY	16,904.78	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	397,042.54	7,798.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	67,482.41	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	269,427.58	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	83,563.33	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	261,872.05	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	51,601.88	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	23,668.27	0.00	INJECTABLE DRUGS	182,182.56	0.00
RADIOLOGY THERAPEUTIC	2,910.10	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,334.09	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	11,530.81	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,167.58	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	187,500.30	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	9,490.50
OTHER IMAGING SERVICE	25,982.32	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	60,404.94	2,763.06			
ONCOLOGY	1,627.01	0.00			
NUCLEAR MEDICINE	3,153.64	404.88			
AUDIOLOGY	3,434.40	0.00			
CARDIOLOGY	84,155.56	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,043.68	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,241.55	20,346.12			
			TOTAL ANCILLARY	4,558,907.09	44,497.17
			TOTAL ACCOMODATIONS	714,840.00	3,454.00
			TOTAL CHARGES	5,273,747.09	47,951.17

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

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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 08/01/13 THROUGH 07/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013311086357	10/17/13 - 10/30/13	11/11/13	0.00	2,397.03	0.00	0.00	0.00
614	2014052078198	02/04/14 - 02/07/14	03/03/14	0.00	1,993.36	0.00	0.00	0.00
615	2014064095729	02/19/14 - 02/27/14	03/10/14	0.00	2,070.02	0.00	0.00	0.00
614	2015012032389	05/02/14 - 05/09/14	01/19/15	0.00	3,030.09	0.00	0.00	0.00
TOTAL				0.00	9,490.50	0.00	0.00	0.00

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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	08/01/13	THROUGH	07/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

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GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/13 THROUGH 07/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,408,188.37	ADJUSTMENTS	374,852.21
COVERED CHARGES	6,909,969.56	CONTRACTUAL ALLOW	4,848,641.55
NON-COVERD CHARGES	498,218.81	TOTAL MEDICAID LIAB	2,061,328.01
		LESS: COB	2,365.70
		LESS: COPAYMENT	5,891.06
		REIMBURSEMENT	2,053,071.25
		ALL OTHER	1,780,695.21
		FEE SCHEDULE-LAB	176,291.41
		INJECTABLE DRUGS	96,084.63

TOTAL NUMBER OF CLAIMS 5,008

PHOEBE SUMTER MEDICAL CENTER
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PROVIDER NUMBER
 000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	598,499.02	316.03	OTHER LAB	55,125.51	743.33
MED/SURG SUPPLY	427,227.88	3,912.29	RECREATIONAL THERAPY	712.81	0.00
LABORATORY-GENERAL	0.00	147.84	EDUCATION & TRAINING	0.00	397.30
RADIOLOGY-DIAGNOSTIC	347,193.38	4,217.99	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	790,036.60	27,159.15	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	64,726.85	35,828.17	FEE SCHEDULE LAB	883,048.26	129,255.45
EKG/ECG	86,091.24	5,976.96	MRI SERVICES	280,684.25	17,891.24
IV THERAPY	254,084.58	47,538.27	PROFESSIONAL FEES	0.00	121.74
OPERATING ROOM	733,815.25	49,812.51	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,380.88	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	21,719.50	11,356.51	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	133,765.65	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,044,074.97	36,494.35	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	104,068.94	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,677.92
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	388,657.40	71,579.92
RADIOLOGY THERAPEUTIC	95,713.18	157.31	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,441.51	2,428.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,805.47	2,760.88	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	16.96	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	82,939.50	4,005.82	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	68,399.41	5,705.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,200.00
OTHER IMAGING SERVICE	197,714.64	9,510.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	19,598.26	460.51			
ONCOLOGY	3,067.82	0.00			
NUCLEAR MEDICINE	35,475.93	6,779.92			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	55,267.62	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	73,972.26	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	48,660.99	20,725.86			
			TOTAL ANCILLARY	6,909,969.56	498,177.73
			TOTAL ACCOMODATIONS	0.00	41.08
			TOTAL CHARGES	6,909,969.56	498,218.81

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GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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OUTPATIENT PAID CLAIMS - % OF CHARGES

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PHOEBE SUMTER MEDICAL CENTER
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PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/13 THROUGH 07/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
591	5914049000064	10/02/13 - 10/02/13	02/24/14	0.00	1,200.00	0.00	0.00	0.00
TOTAL				0.00	1,200.00	0.00	0.00	0.00

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GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/13 THROUGH 07/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,878.79	ADJUSTMENTS	0.00
COVERED CHARGES	11,130.49	CONTRACTUAL ALLOW	5,551.53
NON-COVERD CHARGES	2,748.30	TOTAL MEDICAID LIAB	5,578.96
		LESS: COB	5,572.96
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 13

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,170.84	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	597.34	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	737.16	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,249.77	1,249.77	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,159.01	267.88
EKG/ECG	190.22	190.22	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	117.38	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	196.65	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,874.81	880.71	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	518.35	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	199.99	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	118.97	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	159.72			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	11,130.49	2,748.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,130.49	2,748.30

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GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/13 THROUGH 07/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	423,871.18	ADJUSTMENTS	1,238.62
COVERED CHARGES	407,829.04	CONTRACTUAL ALLOW	374,590.90
NON-COVERD CHARGES	16,042.14	TOTAL MEDICAID LIAB	33,238.14
		LESS: COB	4.97
		LESS: COPAYMENT	1,263.00
		REIMBURSEMENT	31,970.17
		TOTAL NUMBER OF CLAIMS	603

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

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 126 US HWY 280 W
 AMERICUS,GA 31719-8645

PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36,126.95	0.00	OTHER LAB	6,815.07	0.00
MED/SURG SUPPLY	15,152.31	1,125.29	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	32,904.85	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	36,365.48	1,249.77	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	273.57	FEE SCHEDULE LAB	52,302.55	4,501.76
EKG/ECG	3,272.52	0.00	MRI SERVICES	1,993.36	2,246.53
IV THERAPY	2,871.51	627.33	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	707.09	204.16	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	197,020.93	2,626.11	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	3,090.40	689.47
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,375.83	145.83	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	713.82	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,489.70	1,945.36			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	716.76	0.00			
ONCOLOGY	219.13	0.00			
NUCLEAR MEDICINE	1,581.00	154.24			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,933.18	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	176.60	252.72			
			TOTAL ANCILLARY	407,829.04	16,042.14
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	407,829.04	16,042.14

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:45:35
Page: 12

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 08/01/13 THROUGH 07/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,004.65	ADJUSTMENTS	0.00
COVERED CHARGES	2,328.37	CONTRACTUAL ALLOW	816.05
NON-COVERD CHARGES	676.28	TOTAL MEDICAID LIAB	1,512.32
		LESS: COB	1,512.32
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	148.63	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	97.09	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	293.00	16.96
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,446.97	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	342.68	659.32			
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	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,328.37	676.28
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,328.37	676.28

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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 08/01/13 THROUGH 07/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	894,215.39	ADJUSTMENTS	50,307.99
COVERED CHARGES	869,013.69	CONTRACTUAL ALLOW	674,551.44
NON-COVERD CHARGES	25,201.70	TOTAL MEDICAID LIAB	194,462.25
		LESS: COB	0.00
		LESS: COPAYMENT	303.00
		REIMBURSEMENT	194,159.25
		TOTAL NUMBER OF CLAIMS	35

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 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36,334.16	0.00	OTHER LAB	1,018.60	0.00
MED/SURG SUPPLY	27,761.06	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,765.28	239.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,527.79	4,274.62	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,073.85	FEE SCHEDULE LAB	15,300.64	3,261.00
EKG/ECG	570.66	0.00	MRI SERVICES	9,339.85	0.00
IV THERAPY	44,479.80	3,754.94	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	33,771.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	494.72	648.63	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,774.80	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,067.26	836.44	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,321.80	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	591,494.75	9,179.85
RADIOLOGY THERAPEUTIC	54,535.33	344.09	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	253.39	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	233.45	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	10,367.02	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,501.53	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	2,072.79	0.00			
NUCLEAR MEDICINE	0.00	154.24			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,866.36	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,648.24	947.70			
			TOTAL ANCILLARY	869,013.69	25,201.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	869,013.69	25,201.70

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	08/01/13	THROUGH	07/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,991,131.23	ADJUSTMENTS	82,536.65
COVERED CHARGES	1,928,916.40	CONTRACTUAL ALLOW	995,590.21
NON-COVERD CHARGES	62,214.83	TOTAL MEDICAID LIAB	933,326.19
		LESS: COB	10,491.03
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	922,835.16

TOTAL NUMBER OF ADMISSIONS 221

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	750		0	373,500.00		36,158.00
ROUTINE NURSERY	82		0	21,168.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	832		0	394,668.00		36,158.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	54		0	57,897.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	57,897.00		0.00
TOTAL ACCOMODATIONS	886		0	452,565.00		36,158.00

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	90,093.97	0.00	OTHER LAB	6,295.00	0.00
MED/SURG SUPPLY	85,025.74	183.88	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	344,778.00	0.00	EDUCATION & TRAINING	336.00	0.00
RADIOLOGY-DIAGNOSTIC	24,932.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	87,018.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,878.08	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	23,780.00	0.00	MRI SERVICES	3,506.00	0.00
IV THERAPY	145,579.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	59,934.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	91,157.00	452.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	63,177.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	26,219.00	0.00	AMBULANCE	0.00	799.50
GI SERVICES	3,650.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	25,590.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,769.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	295,378.83	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,816.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,826.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	5,445.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,776.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	755.78	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,626.45
OTHER IMAGING SERVICE	2,447.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	27,110.00	22,995.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	785.00	0.00			
AUDIOLOGY	2,100.00	0.00			
CARDIOLOGY	15,954.00	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	21,404.00	0.00			
			TOTAL ANCILLARY	1,476,351.40	26,056.83
			TOTAL ACCOMODATIONS	452,565.00	36,158.00
			TOTAL CHARGES	1,928,916.40	62,214.83

Report : CLM-0800-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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APPLING HOSPITAL
163 E TOLLISON ST
BAXLEY,GA 31513-0120

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
30	2213298012461	10/02/13 - 10/07/13	10/28/13	0.00	16.00	0.00	0.00	0.00
1	2214073006734	02/26/14 - 03/03/14	03/17/14	0.00	926.00	0.00	0.00	0.00
2	2214128010150	04/10/14 - 04/15/14	05/12/14	0.00	64.45	0.00	0.00	0.00
30	2214128010150	04/10/14 - 04/15/14	05/12/14	0.00	620.00	0.00	0.00	0.00
TOTAL				0.00	1,626.45	0.00	0.00	0.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:45:47
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APPLING HOSPITAL
163 E TOLLISON ST
BAXLEY,GA 31513-0120

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,534,917.99	ADJUSTMENTS	106,727.33
COVERED CHARGES	2,196,665.11	CONTRACTUAL ALLOW	1,740,889.05
NON-COVERD CHARGES	338,252.88	TOTAL MEDICAID LIAB	455,776.06
		LESS: COB	543.75
		LESS: COPAYMENT	1,818.00
		REIMBURSEMENT	453,414.31
		ALL OTHER	363,400.62
		FEE SCHEDULE-LAB	83,313.54
		INJECTABLE DRUGS	6,700.15

TOTAL NUMBER OF CLAIMS 2,048

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

PROVIDER NUMBER
 000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	80,010.94	7,518.00	OTHER LAB	15,506.00	0.00
MED/SURG SUPPLY	64,120.11	1,448.96	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	261.00	EDUCATION & TRAINING	0.00	560.00
RADIOLOGY-DIAGNOSTIC	103,243.00	0.00	OTHER THERAPEUTIC SVC	119.00	119.00
CT SCAN	174,091.56	28,043.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	11,466.00	1,200.00	FEE SCHEDULE LAB	698,543.00	199,533.00
EKG/ECG	29,055.00	575.00	MRI SERVICES	82,656.00	0.00
IV THERAPY	242,360.00	11,961.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	73,256.00	2,986.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,686.00	4,574.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	25,716.00	13,545.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	36,905.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	15,330.00	1,460.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	262,926.60	1,736.40	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	26,174.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	47,794.90	24,715.06
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,042.00	318.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,658.00	177.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	8,456.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	222.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	375.00	889.46
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	39,388.00	6,679.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	24,722.00	17,739.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	21,040.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	20,503.00	2,617.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,092.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	84,886.00	920.00			
			TOTAL ANCILLARY	2,196,665.11	338,252.88
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,196,665.11	338,252.88

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:45:54
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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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,188.03	ADJUSTMENTS	0.00
COVERED CHARGES	8,476.10	CONTRACTUAL ALLOW	5,108.77
NON-COVERD CHARGES	3,711.93	TOTAL MEDICAID LIAB	3,367.33
		LESS: COB	3,364.33
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 12

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	41.40	46.12	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	973.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,198.00	2,270.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,403.00	1,196.00
EKG/ECG	155.00	70.00	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	2,286.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7.70	129.81
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	8,476.10	3,711.93
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,476.10	3,711.93

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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APPLING HOSPITAL
163 E TOLLISON ST
BAXLEY,GA 31513-0120

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	88,511.73	ADJUSTMENTS	158.82
COVERED CHARGES	84,648.78	CONTRACTUAL ALLOW	75,138.98
NON-COVERD CHARGES	3,862.95	TOTAL MEDICAID LIAB	9,509.80
		LESS: COB	0.00
		LESS: COPAYMENT	282.00
		REIMBURSEMENT	9,227.80
		TOTAL NUMBER OF CLAIMS	170

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,906.58	193.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,137.21	20.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,094.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,361.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	21,333.00	3,157.00
EKG/ECG	845.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,856.00	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	1,265.00	142.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	42,469.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,161.99	276.95
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	240.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	980.00	0.00			
			TOTAL ANCILLARY	84,648.78	3,862.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	84,648.78	3,862.95

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,443.38	ADJUSTMENTS	0.00
COVERED CHARGES	2,063.38	CONTRACTUAL ALLOW	1,607.97
NON-COVERD CHARGES	380.00	TOTAL MEDICAID LIAB	455.41
		LESS: COB	455.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 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	279.00	0.00
MED/SURG SUPPLY	55.38	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	971.00	360.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	205.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	553.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	20.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,063.38	380.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,063.38	380.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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	09/01/13	THROUGH	08/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	09/01/13	THROUGH	08/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF 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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,348,543.81	ADJUSTMENTS	444,533.47
COVERED CHARGES	25,737,742.81	CONTRACTUAL ALLOW	16,983,443.13
NON-COVERD CHARGES	1,610,801.00	TOTAL MEDICAID LIAB	8,754,299.68
		LESS: COB	10,060.65
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,744,239.03

TOTAL NUMBER OF ADMISSIONS 1,095

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5,654		6	3,154,932.00		1,231,981.00
ROUTINE NURSERY	100		0	51,278.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5,754		6	3,206,210.00		1,231,981.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	964		0	1,234,645.00		10,730.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		242	0.00		189,420.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	964		242	1,234,645.00		200,150.00
TOTAL ACCOMODATIONS	6,718		248	4,440,855.00		1,432,131.00

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,687,741.24	15,413.00	OTHER LAB	81,676.00	0.00
MED/SURG SUPPLY	1,951,061.00	7,130.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,129,413.00	13,486.00	EDUCATION & TRAINING	92.00	0.00
RADIOLOGY-DIAGNOSTIC	630,007.00	0.00	OTHER THERAPEUTIC SVC	0.00	11,880.00
CT SCAN	1,163,618.00	32,188.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	243,656.38	1,524.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	43,765.00	0.00	MRI SERVICES	227,466.00	0.00
IV THERAPY	984.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,750,976.00	8,060.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	108,495.00	284.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	806,231.00	1,416.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	130,775.00	261.00	AMBULANCE	0.00	0.00
GI SERVICES	113,510.00	2,721.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	771,892.00	6,050.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	140,455.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	101,622.00	0.00	INJECTABLE DRUGS	156.00	0.00
RADIOLOGY THERAPEUTIC	106,541.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	191,466.08	1,763.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	88,107.03	1,516.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	99,353.08	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	9,340.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	340.00	IMPL DEV CHARGE PATIENTS	1,867,884.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	67,496.00	27,790.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	225,835.00	37,410.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	83,056.00	0.00			
AUDIOLOGY	3,483.00	0.00			
CARDIOLOGY	416,677.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	32,821.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	30,577.00	98.00			
			TOTAL ANCILLARY	21,296,887.81	178,670.00
			TOTAL ACCOMODATIONS	4,440,855.00	1,432,131.00
			TOTAL CHARGES	25,737,742.81	1,610,801.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:46:11
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,577,306.08	ADJUSTMENTS	810,761.82
COVERED CHARGES	18,712,086.13	CONTRACTUAL ALLOW	13,840,761.50
NON-COVERD CHARGES	1,865,219.95	TOTAL MEDICAID LIAB	4,871,324.63
		LESS: COB	3,106.93
		LESS: COPAYMENT	17,320.79
		REIMBURSEMENT	4,850,896.91
		ALL OTHER	3,596,232.32
		FEE SCHEDULE-LAB	331,535.73
		INJECTABLE DRUGS	923,128.86
		TOTAL NUMBER OF CLAIMS	10,322

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	355,058.20	19,366.00	OTHER LAB	88,176.00	0.00
MED/SURG SUPPLY	840,320.00	971.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	760,836.00	7,436.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,281,394.00	220,850.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	96,240.00	43,392.29	FEE SCHEDULE LAB	2,599,253.12	432,206.50
EKG/ECG	59,965.00	1,232.00	MRI SERVICES	411,262.00	10,649.00
IV THERAPY	787,540.00	63,812.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,307,196.43	148,218.57	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	43,660.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	86,852.00	157,988.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	120,532.00	5,440.00	AMBULANCE	0.00	0.00
GI SERVICES	317,364.69	34,803.31	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,256,273.00	12,837.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	242,351.00	264.00	DRUG-SPECIFIC/HOME IV	0.00	4,400.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,920,222.69	508,513.03
RADIOLOGY THERAPEUTIC	1,215,038.00	1,963.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	12,894.00	10,111.05	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,426.00	10,594.20	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	216,136.00	9,827.00	TRAUMA RESPONSE	0.00	1,129.00
PSYCHIATRIC SERVICES	2,295.00	0.00	IMPL DEV CHARGE PATIENTS	114,557.00	3,318.00
LITHOTRIPSY	8,196.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	547,532.00	34,287.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	57,725.00	14,914.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	186,529.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	277,002.00	73,050.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	157,902.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	332,358.00	33,648.00			
			TOTAL ANCILLARY	18,712,086.13	1,865,219.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,712,086.13	1,865,219.95

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	175,004.00	ADJUSTMENTS	0.00
COVERED CHARGES	99,598.00	CONTRACTUAL ALLOW	11,561.65
NON-COVERD CHARGES	75,406.00	TOTAL MEDICAID LIAB	88,036.35
		LESS: COB	87,948.04
		LESS: COPAYMENT	88.31
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 98

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	914.00	0.00	OTHER LAB	2,258.00	0.00
MED/SURG SUPPLY	3,141.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,004.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,143.00	66,314.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	26,227.00	4,053.00
EKG/ECG	452.00	0.00	MRI SERVICES	0.00	1,292.00
IV THERAPY	7,042.00	345.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,698.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,856.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	623.00	202.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	560.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,854.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,249.00	1,129.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	428.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,287.00	565.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,257.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,319.00	1,401.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,631.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,033.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,350.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,272.00	105.00			
			TOTAL ANCILLARY	99,598.00	75,406.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	99,598.00	75,406.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	431,927.00	ADJUSTMENTS	1,944.84
COVERED CHARGES	387,569.50	CONTRACTUAL ALLOW	361,501.47
NON-COVERD CHARGES	44,357.50	TOTAL MEDICAID LIAB	26,068.03
		LESS: COB	0.00
		LESS: COPAYMENT	831.00
		REIMBURSEMENT	25,237.03
		TOTAL NUMBER OF CLAIMS	466

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,176.00	0.00	OTHER LAB	1,056.00	0.00
MED/SURG SUPPLY	8,366.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	44,181.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,523.00	3,442.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	93,680.50	11,073.50
EKG/ECG	1,648.00	56.00	MRI SERVICES	802.00	802.00
IV THERAPY	32,286.00	805.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,764.00	808.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	261.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	162,503.00	70.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,490.00	26,901.00
RADIOLOGY THERAPEUTIC	403.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,691.00	139.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	387,569.50	44,357.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	387,569.50	44,357.50

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,532.00	ADJUSTMENTS	0.00
COVERED CHARGES	6,393.00	CONTRACTUAL ALLOW	2,836.09
NON-COVERD CHARGES	139.00	TOTAL MEDICAID LIAB	3,556.91
		LESS: COB	3,547.91
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	351.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	359.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,062.00	0.00
EKG/ECG	56.00	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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,952.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	442.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	139.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,393.00	139.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,393.00	139.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,136,098.81	ADJUSTMENTS	132,477.59
COVERED CHARGES	2,822,299.89	CONTRACTUAL ALLOW	2,252,701.26
NON-COVERD CHARGES	313,798.92	TOTAL MEDICAID LIAB	569,598.63
		LESS: COB	0.00
		LESS: COPAYMENT	393.00
		REIMBURSEMENT	569,205.63

TOTAL NUMBER OF CLAIMS 101

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36,246.00	275.00	OTHER LAB	1,103.00	0.00
MED/SURG SUPPLY	233,355.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	60,058.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	39,596.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,888.17	FEE SCHEDULE LAB	52,391.00	10,939.00
EKG/ECG	1,700.00	504.00	MRI SERVICES	3,493.00	2,365.00
IV THERAPY	83,327.00	6,110.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	295,171.45	40,903.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,615.00	84.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,860.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,561.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	45,473.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	877,443.44	78,335.00
RADIOLOGY THERAPEUTIC	616,861.00	97,824.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,747.00	343.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	355,963.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	208.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,943.00	1,694.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,842.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	68,336.00	68,271.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	627.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	18,380.00	4,263.00			
			TOTAL ANCILLARY	2,822,299.89	313,798.92
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,822,299.89	313,798.92

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:46:50
Page: 14

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	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 00:46:58
 Page: 1

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000074A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	63,778,863.08	ADJUSTMENTS	5,466,151.77
COVERED CHARGES	62,651,474.74	CONTRACTUAL ALLOW	45,474,058.92
NON-COVERD CHARGES	1,127,388.34	TOTAL MEDICAID LIAB	17,177,415.82
		LESS: COB	205,730.71
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	16,971,685.11

TOTAL NUMBER OF ADMISSIONS 1,917

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7,043		46	6,101,220.00		684,743.00
ROUTINE NURSERY	881		56	969,255.00		188,495.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		53.00
TOTAL ROUTINE	7,924		102	7,070,475.00		873,291.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,336		0	2,668,661.00		0.00
NICU	295		0	780,878.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,631		0	3,449,539.00		0.00
TOTAL ACCOMODATIONS	9,555		102	10,520,014.00		873,291.00

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,038,844.78	20,512.57	OTHER LAB	351,756.45	0.00
MED/SURG SUPPLY	3,265,182.06	76,916.59	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,217,078.58	17,602.99	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,039,834.34	1,453.43	OTHER THERAPEUTIC SVC	0.00	5,842.20
CT SCAN	2,344,983.48	16,541.48	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	203,760.32	3,259.58	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,638,248.92	0.00	MRI SERVICES	576,275.36	0.00
IV THERAPY	262,104.72	685.90	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,492,111.14	2,258.03	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,035,127.47	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,658,417.08	6,242.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	222,430.36	0.00	AMBULANCE	0.00	0.00
GI SERVICES	456,168.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,699,083.75	1,265.79	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	511,568.08	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	575,507.60	0.00	INJECTABLE DRUGS	1,985,811.05	2,055.42
RADIOLOGY THERAPEUTIC	188,651.00	4,554.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	93,126.98	1,150.44	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	117,161.80	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	444,527.48	5,171.96	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	216.96	16,983.03	TRAUMA RESPONSE	0.00	28,929.60
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,206,027.29	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	7,859.49
OTHER IMAGING SERVICE	359,574.28	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	758,603.43	34,208.32			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	177,846.14	603.77			
AUDIOLOGY	84,275.10	0.00			
CARDIOLOGY	1,867,917.89	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	85,388.45	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	173,850.40	0.00			
			TOTAL ANCILLARY	52,131,460.74	254,097.34
			TOTAL ACCOMODATIONS	10,520,014.00	873,291.00
			TOTAL CHARGES	62,651,474.74	1,127,388.34

Report : CLM-0800-0
Process : CLMJ0800
Location: CLMP8000

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

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

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
392	2015048067625	05/17/14 - 05/21/14	02/23/15	0.00	731.49	0.00	0.00	0.00
392	2215068004636	09/29/14 - 01/10/15	03/16/15	0.00	7,128.00	0.00	0.00	0.00
TOTAL				0.00	7,859.49	0.00	0.00	0.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

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

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SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	61,578.65	ADJUSTMENTS	0.00
COVERED CHARGES	57,302.65	CONTRACTUAL ALLOW	21,550.35
NON-COVERD CHARGES	4,276.00	TOTAL MEDICAID LIAB	35,752.30
		LESS: COB	35,752.30
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5		0	3,584.00		360.00
ROUTINE NURSERY	0		4	0.00		3,916.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5		4	3,584.00		4,276.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1		0	1,999.00		0.00
NICU	1		0	2,600.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2		0	4,599.00		0.00
TOTAL ACCOMODATIONS	7		4	8,183.00		4,276.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,421.71	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,897.68	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,199.46	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,766.20	0.00	OTHER THERAPEUTIC SVC	0.00	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	2,712.90	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	11,404.49	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,245.33	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	947.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,650.01	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,241.87	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	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	245.70	0.00			
CARDIOLOGY	1,800.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,587.30	0.00			
			TOTAL ANCILLARY	49,119.65	0.00
			TOTAL ACCOMODATIONS	8,183.00	4,276.00
			TOTAL CHARGES	57,302.65	4,276.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	34,629,893.41	ADJUSTMENTS	1,549,578.93
COVERED CHARGES	31,853,104.46	CONTRACTUAL ALLOW	25,755,071.89
NON-COVERD CHARGES	2,776,788.95	TOTAL MEDICAID LIAB	6,098,032.57
		LESS: COB	17,635.24
		LESS: COPAYMENT	15,862.46
		REIMBURSEMENT	6,064,534.87
		ALL OTHER	5,109,183.46
		FEE SCHEDULE-LAB	690,078.59
		INJECTABLE DRUGS	265,272.82

TOTAL NUMBER OF CLAIMS 13,525

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

PROVIDER NUMBER
 000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	895,830.31	140.20	OTHER LAB	350,000.36	918.23
MED/SURG SUPPLY	877,812.81	2,496.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,291,737.94	15,567.49	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,068,598.82	147,577.92	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	49,975.47	23,774.50	FEE SCHEDULE LAB	5,605,058.50	1,180,388.41
EKG/ECG	432,615.14	302,595.78	MRI SERVICES	960,336.92	26,275.20
IV THERAPY	1,125,189.87	64,235.61	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,149,712.84	115,579.30	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,657.43	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	370,438.81	64,438.41	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	157,957.38	0.00	AMBULANCE	0.00	0.00
GI SERVICES	277,579.27	9,312.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,308,520.22	14,307.58	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	433,012.10	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,682,514.79	463,802.09
RADIOLOGY THERAPEUTIC	365,102.56	989.50	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,461.13	3,878.78	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	19,406.90	5,780.48	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	23,369.76	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	125,668.12	3,194.89	TRAUMA RESPONSE	0.00	14,464.80
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	397,377.59	10,695.82
LITHOTRIPSY	36,486.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	828,505.33	52,820.26			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	205,716.91	574.04			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,590,100.38	30,383.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,064,686.72	192,387.93			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	421,860.70	277.20			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	751,183.14	6,562.67			
			TOTAL ANCILLARY	31,853,104.46	2,776,788.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	31,853,104.46	2,776,788.95

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	463,472.34	ADJUSTMENTS	0.00
COVERED CHARGES	385,069.62	CONTRACTUAL ALLOW	273,778.65
NON-COVERD CHARGES	78,402.72	TOTAL MEDICAID LIAB	111,290.97
		LESS: COB	111,098.96
		LESS: COPAYMENT	192.01
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 123

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,254,924.45	ADJUSTMENTS	2,041.72
COVERED CHARGES	1,214,279.29	CONTRACTUAL ALLOW	1,166,282.77
NON-COVERD CHARGES	40,645.16	TOTAL MEDICAID LIAB	47,996.52
		LESS: COB	44.92
		LESS: COPAYMENT	1,725.01
		REIMBURSEMENT	46,226.59
		TOTAL NUMBER OF CLAIMS	858

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
 000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,225.95	0.00	OTHER LAB	6,226.62	0.00
MED/SURG SUPPLY	8,544.15	647.36	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	72,038.28	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	64,951.68	2,209.92	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	256,017.35	24,104.23
EKG/ECG	12,890.64	0.00	MRI SERVICES	12,025.08	0.00
IV THERAPY	44,090.12	2,280.04	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,418.81	700.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	652,109.39	2,219.82	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	37,435.45	5,606.49
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	255.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	15.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	16,068.75	2,877.30			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	8,458.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,509.02	0.00			
			TOTAL ANCILLARY	1,214,279.29	40,645.16
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,214,279.29	40,645.16

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,393.74	ADJUSTMENTS	0.00
COVERED CHARGES	7,393.74	CONTRACTUAL ALLOW	4,200.96
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	3,192.78
		LESS: COB	3,192.78
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
 000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	79.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	772.70	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	1,760.31	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	3,940.12	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	6.51	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	835.10	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,393.74	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,393.74	0.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,132,742.80	ADJUSTMENTS	260,680.51
COVERED CHARGES	3,920,243.50	CONTRACTUAL ALLOW	3,302,138.17
NON-COVERD CHARGES	212,499.30	TOTAL MEDICAID LIAB	618,105.33
		LESS: COB	0.00
		LESS: COPAYMENT	953.50
		REIMBURSEMENT	617,151.83
		TOTAL NUMBER OF CLAIMS	109

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER
 000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	83,468.84	0.00	OTHER LAB	3,436.44	0.00
MED/SURG SUPPLY	244,168.86	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,075.98	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	55,119.56	8,644.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,983.71	FEE SCHEDULE LAB	126,953.87	39,665.07
EKG/ECG	7,059.16	20,521.20	MRI SERVICES	12,372.24	0.00
IV THERAPY	123,565.22	814.30	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	425,554.27	10,839.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	730.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	17,808.90	0.00	AMBULANCE	0.00	0.00
GI SERVICES	17,054.00	1.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,619.17	90.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	33,618.92	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,183,192.27	66,395.15
RADIOLOGY THERAPEUTIC	237,916.92	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	244.65	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,132.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	779,844.45	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	954.80	1,207.10			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	168,348.87	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	11,549.96	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	287,353.14	62,093.32			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	65,345.66	0.00			
			TOTAL ANCILLARY	3,920,243.50	212,499.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,920,243.50	212,499.30

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER
000000074A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF 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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,063,104.20	ADJUSTMENTS	1,622.91
COVERED CHARGES	1,996,996.01	CONTRACTUAL ALLOW	1,477,337.70
NON-COVERD CHARGES	66,108.19	TOTAL MEDICAID LIAB	519,658.31
		LESS: COB	3,683.33
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	515,974.98

TOTAL NUMBER OF ADMISSIONS 82

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	275		0	174,350.00		6,985.00
ROUTINE NURSERY	8		0	5,015.70		43.10
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	283		0	179,365.70		7,028.10
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	58		0	66,744.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	66,744.00		0.00
TOTAL ACCOMODATIONS	341		0	246,109.70		7,028.10

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	377,876.48	0.00	OTHER LAB	10,523.50	0.00
MED/SURG SUPPLY	252,400.57	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	318,686.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	43,017.76	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	54,273.30	14,494.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	26,314.40	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	23,324.00	0.00	MRI SERVICES	17,820.30	0.00
IV THERAPY	5,060.00	28,639.69	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	141,259.90	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,019.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	95,965.40	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,531.20	0.00	AMBULANCE	0.00	0.00
GI SERVICES	10,822.10	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	72,430.80	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,991.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	832.90	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	18,163.30	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,645.30	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	232,235.80	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,020.20	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,654.20	15,946.40			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,122.80	0.00			
AUDIOLOGY	2,140.50	0.00			
CARDIOLOGY	7,742.70	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	6,012.90	0.00			
			TOTAL ANCILLARY	1,750,886.31	59,080.09
			TOTAL ACCOMODATIONS	246,109.70	7,028.10
			TOTAL CHARGES	1,996,996.01	66,108.19

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,016,776.99	ADJUSTMENTS	16,211.40
COVERED CHARGES	1,519,691.92	CONTRACTUAL ALLOW	1,078,722.99
NON-COVERD CHARGES	497,085.07	TOTAL MEDICAID LIAB	440,968.93
		LESS: COB	130.78
		LESS: COPAYMENT	1,218.00
		REIMBURSEMENT	439,620.15
		ALL OTHER	399,819.40
		FEE SCHEDULE-LAB	39,800.75
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	1,492

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,540.88	122,264.49	OTHER LAB	14,251.20	0.00
MED/SURG SUPPLY	101,770.76	442.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	700.60	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	150,903.70	5,548.30	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	122,869.00	141,431.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	12,570.20	8,109.30	FEE SCHEDULE LAB	465,091.60	118,300.60
EKG/ECG	27,076.70	5,568.90	MRI SERVICES	125,063.70	7,130.90
IV THERAPY	5,768.40	19,643.98	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	77,300.11	7,301.10	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,352.26	1,342.30	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	37,467.20	4,242.90	CAST ROOM	0.00	0.00
EMERGENCY ROOM	253,673.70	39,058.80	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,588.60	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	4,351.90	5,162.30	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,238.30	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	12,730.10	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	41,775.20	8,694.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	695.60	796.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,873.90	0.00			
AUDIOLOGY	225.30	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	31,740.91	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,772.70	1,347.00			
			TOTAL ANCILLARY	1,519,691.92	497,085.07
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,519,691.92	497,085.07

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,927.31	ADJUSTMENTS	0.00
COVERED CHARGES	3,816.81	CONTRACTUAL ALLOW	1,212.71
NON-COVERD CHARGES	1,110.50	TOTAL MEDICAID LIAB	2,604.10
		LESS: COB	2,598.76
		LESS: COPAYMENT	5.34
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	113.51	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	90.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	656.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	307.90	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,316.80	415.90
EKG/ECG	178.70	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	202.40	165.00	PROFESSIONAL FEES	0.00	380.80
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	951.10	148.80	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,816.81	1,110.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,816.81	1,110.50

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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Page: 8

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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	171,126.03	ADJUSTMENTS	135.00
COVERED CHARGES	137,576.30	CONTRACTUAL ALLOW	126,776.30
NON-COVERD CHARGES	33,549.73	TOTAL MEDICAID LIAB	10,800.00
		LESS: COB	0.00
		LESS: COPAYMENT	414.00
		REIMBURSEMENT	10,386.00
		TOTAL NUMBER OF CLAIMS	216

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	8,400.20	OTHER LAB	812.80	0.00
MED/SURG SUPPLY	2,020.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,558.20	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,470.70	14,631.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	36,154.70	6,056.80
EKG/ECG	2,144.40	178.70	MRI SERVICES	0.00	0.00
IV THERAPY	101.20	1,021.03	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	296.10	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,432.40	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	64,176.80	2,427.30	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,106.80	834.10			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	301.30	0.00			
			TOTAL ANCILLARY	137,576.30	33,549.73
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	137,576.30	33,549.73

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	74,732.69	ADJUSTMENTS	0.00
COVERED CHARGES	69,118.60	CONTRACTUAL ALLOW	55,688.53
NON-COVERD CHARGES	5,614.09	TOTAL MEDICAID LIAB	13,430.07
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	13,421.07

TOTAL NUMBER OF CLAIMS 3

Report : CLM-0812-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	69.00	5,260.05	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	20,207.50	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	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	354.04	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,473.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	98.70	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	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	798.80	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	36,471.10	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	69,118.60	5,614.09
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	69,118.60	5,614.09

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,648,740.82	ADJUSTMENTS	235,702.38
COVERED CHARGES	5,593,897.09	CONTRACTUAL ALLOW	3,295,252.19
NON-COVERD CHARGES	54,843.73	TOTAL MEDICAID LIAB	2,298,644.90
		LESS: COB	31,736.49
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,266,908.41

TOTAL NUMBER OF ADMISSIONS 272

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	573		0	422,301.00		74.49
ROUTINE NURSERY	59		0	35,419.27		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	632		0	457,720.27		74.49
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	644		0	865,908.02		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	644		0	865,908.02		0.00
TOTAL ACCOMODATIONS	1,276		0	1,323,628.29		74.49

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	625,392.47	0.00	OTHER LAB	9,844.34	0.00
MED/SURG SUPPLY	447,072.34	348.55	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	827,487.16	624.42	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	67,143.80	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	258,956.13	4,770.30	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	19,644.05	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	18,780.42	0.00	MRI SERVICES	14,793.10	0.00
IV THERAPY	30,494.65	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	156,268.01	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	57,018.16	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	245,361.38	15.86	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	43,754.16	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	143,356.98	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,035.70	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	26,654.11	0.00	INJECTABLE DRUGS	897,439.12	0.00
RADIOLOGY THERAPEUTIC	20,568.05	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,056.60	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,390.07	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	12,884.08	2,342.56	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,618.10	5,968.38	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	61,374.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	3,259.75
OTHER IMAGING SERVICE	22,156.24	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	94,406.07	37,439.42			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	48,619.24	0.00			
AUDIOLOGY	2,808.40	0.00			
CARDIOLOGY	91,909.54	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,982.08	0.00			
			TOTAL ANCILLARY	4,270,268.80	54,769.24
			TOTAL ACCOMODATIONS	1,323,628.29	74.49
			TOTAL CHARGES	5,593,897.09	54,843.73

Report : CLM-0800-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013351032870	12/01/13 - 12/10/13	12/23/13	0.00	3,259.75	0.00	0.00	0.00
TOTAL				0.00	3,259.75	0.00	0.00	0.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:48:47
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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	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:48:48
Page: 5

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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,990,562.66	ADJUSTMENTS	277,325.20
COVERED CHARGES	6,446,168.73	CONTRACTUAL ALLOW	5,028,924.05
NON-COVERD CHARGES	544,393.93	TOTAL MEDICAID LIAB	1,417,244.68
		LESS: COB	1,442.63
		LESS: COPAYMENT	4,232.56
		REIMBURSEMENT	1,411,569.49
		ALL OTHER	1,118,403.29
		FEE SCHEDULE-LAB	248,458.09
		INJECTABLE DRUGS	44,708.11

TOTAL NUMBER OF CLAIMS 5,176

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	153,737.24	2,575.74	OTHER LAB	22,236.94	0.00
MED/SURG SUPPLY	257,500.80	2,597.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	126.48	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	246,850.13	1,864.97	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,034,410.59	21,658.53	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,230.53	466.32	FEE SCHEDULE LAB	1,664,019.74	333,459.90
EKG/ECG	58,555.76	1,312.61	MRI SERVICES	153,855.96	0.00
IV THERAPY	250,640.85	10,193.59	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	205,964.56	8,060.20	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	16,819.65	3,980.08	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	129,668.30	1,045.54	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,016,932.29	4,219.40	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	35,202.16	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	225,037.56	60,738.43
RADIOLOGY THERAPEUTIC	354,867.87	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	147.45	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	597.97	1,879.10	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	1,989.46	2,792.12	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	52,609.34	4,785.20
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	282.43
OTHER IMAGING SERVICE	178,930.06	8,373.56			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	22,441.79	11,333.71			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	145,362.01	59,820.68			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	53,850.56	0.00			
AMBULATORY SURGERY	352.30	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	79,254.08	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	79,102.78	2,827.84			
			TOTAL ANCILLARY	6,446,168.73	544,393.93
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,446,168.73	544,393.93

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
60	5914112001645	03/17/14 - 03/17/14	04/28/14	0.00	120.62	0.00	373.00	0.00
60	2214239005361	06/20/14 - 06/20/14	09/01/14	0.00	41.19	0.00	0.00	0.00
-1	9715170957020	03/17/14 - 03/17/14	06/29/15	0.00	120.62	0.00	0.00	0.00
TOTAL				0.00	282.43	0.00	373.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,807.45	ADJUSTMENTS	0.00
COVERED CHARGES	8,079.74	CONTRACTUAL ALLOW	7,054.13
NON-COVERD CHARGES	727.71	TOTAL MEDICAID LIAB	1,025.61
		LESS: COB	1,025.61
		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

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	376.93	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	179.25	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	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,840.93	665.06
EKG/ECG	100.97	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	304.17	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,177.15	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	199.46	21.46
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	711.93	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	8,079.74	727.71
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,079.74	727.71

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	389,468.65	ADJUSTMENTS	2,391.36
COVERED CHARGES	371,414.59	CONTRACTUAL ALLOW	345,538.04
NON-COVERD CHARGES	18,054.06	TOTAL MEDICAID LIAB	25,876.55
		LESS: COB	60.00
		LESS: COPAYMENT	891.00
		REIMBURSEMENT	24,925.55
		TOTAL NUMBER OF CLAIMS	467

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,149.93	68.68	OTHER LAB	2,918.88	0.00
MED/SURG SUPPLY	5,073.48	122.22	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	65.06	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,999.32	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	49,818.11	1,084.16	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	72,217.65	7,125.79
EKG/ECG	1,817.46	0.00	MRI SERVICES	7,280.80	0.00
IV THERAPY	19,448.98	227.69	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	404.64	402.08	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	159,428.68	2,243.15	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	14,724.31	3,384.08
RADIOLOGY THERAPEUTIC	11,282.29	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	125.86	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	126.48
OTHER IMAGING SERVICE	8,389.01	3,078.81			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,461.05	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	371,414.59	18,054.06
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	371,414.59	18,054.06

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
8470	2214142004922	04/17/14 - 04/17/14	05/26/14	0.00	126.48	0.00	0.00	0.00
TOTAL				0.00	126.48	0.00	0.00	0.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,934.80	ADJUSTMENTS	0.00
COVERED CHARGES	1,577.10	CONTRACTUAL ALLOW	1,504.71
NON-COVERD CHARGES	357.70	TOTAL MEDICAID LIAB	72.39
		LESS: COB	72.39
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34.32	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	727.53	43.36
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	417.66	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	397.59	314.34			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,577.10	357.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,577.10	357.70

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
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SUMMARY TYPE VII

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	76,550.78	ADJUSTMENTS	5,604.45
COVERED CHARGES	76,550.78	CONTRACTUAL ALLOW	59,924.77
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	16,626.01
		LESS: COB	0.00
		LESS: COPAYMENT	108.00
		REIMBURSEMENT	16,518.01
		TOTAL NUMBER OF CLAIMS	3

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 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	29,344.23	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	47,206.55	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	76,550.78	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	76,550.78	0.00

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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Page: 17

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	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF 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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,549,880.26	ADJUSTMENTS	96,074.72
COVERED CHARGES	1,466,021.19	CONTRACTUAL ALLOW	778,262.50
NON-COVERD CHARGES	83,859.07	TOTAL MEDICAID LIAB	687,758.69
		LESS: COB	13,943.90
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	673,814.79

TOTAL NUMBER OF ADMISSIONS 95

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	338		20	202,800.00		69,918.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	338		20	202,800.00		69,918.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	31		0	45,229.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	45,229.00		0.00
TOTAL ACCOMODATIONS	369		20	248,029.00		69,918.00

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	321,729.27	0.00	OTHER LAB	13,785.00	0.00
MED/SURG SUPPLY	115,077.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	238,534.44	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,278.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	91,077.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	17,261.08	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	22,446.00	0.00	MRI SERVICES	2,039.00	0.00
IV THERAPY	4,840.97	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	40,062.92	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	56,894.09	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,605.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	104,383.06	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,822.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,974.19	0.00	INJECTABLE DRUGS	2,598.48	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,097.22	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,763.71	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	69,645.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,723.00
OTHER IMAGING SERVICE	6,671.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	19,094.40	12,218.07			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	40,104.36	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	12,209.00	0.00			
			TOTAL ANCILLARY	1,217,992.19	13,941.07
			TOTAL ACCOMODATIONS	248,029.00	69,918.00
			TOTAL CHARGES	1,466,021.19	83,859.07

Report : CLM-0800-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:49:18
Page: 3

RESTORATION HEALTHCARE OF COMMERCE, LLC PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
70 MEDICAL CENTER DR 000000151A SERVICE DATES 01/01/14 THROUGH 12/31/14
COMMERCE,GA 30529-1078 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014297000021	09/24/14 - 09/25/14	10/27/14	0.00	1,723.00	0.00	0.00	0.00
TOTAL				0.00	1,723.00	0.00	0.00	0.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:49:20
Page: 5

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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,956,018.80	ADJUSTMENTS	52,605.01
COVERED CHARGES	1,698,722.47	CONTRACTUAL ALLOW	1,357,099.79
NON-COVERD CHARGES	257,296.33	TOTAL MEDICAID LIAB	341,622.68
		LESS: COB	0.00
		LESS: COPAYMENT	1,683.00
		REIMBURSEMENT	339,939.68
		ALL OTHER	300,581.14
		FEE SCHEDULE-LAB	36,748.20
		INJECTABLE DRUGS	2,610.34
		TOTAL NUMBER OF CLAIMS	1,484

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,926.57	22,530.14	OTHER LAB	10,007.00	0.00
MED/SURG SUPPLY	50,858.00	1,092.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	122.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	121,228.23	3,481.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	192,508.00	22,600.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	12,019.00	460.00	FEE SCHEDULE LAB	347,478.68	111,414.70
EKG/ECG	31,218.00	1,806.00	MRI SERVICES	85,406.00	0.00
IV THERAPY	109,779.74	3,812.20	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	76,734.37	20,623.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,575.05	381.04	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,848.00	770.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	429,430.92	2,841.42	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,164.00	11,043.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	55,767.10	35,833.60
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	1,811.91	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,670.88	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	335.00	9,480.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	37,656.57	1,955.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,606.58	1,638.40			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	34,206.66	1,179.54			
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	46,969.00	750.00			
			TOTAL ANCILLARY	1,698,722.47	257,296.33
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,698,722.47	257,296.33

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,530.13	ADJUSTMENTS	0.00
COVERED CHARGES	5,719.79	CONTRACTUAL ALLOW	5,598.34
NON-COVERD CHARGES	810.34	TOTAL MEDICAID LIAB	121.45
		LESS: COB	118.45
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 4

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	85.00	70.48	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	182.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	338.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,361.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,447.24	531.00
EKG/ECG	129.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	380.13	104.43	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,722.42	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	75.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	104.43	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	5,719.79	810.34
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,719.79	810.34

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	227,080.86	ADJUSTMENTS	1,011.86
COVERED CHARGES	218,576.88	CONTRACTUAL ALLOW	200,060.74
NON-COVERD CHARGES	8,503.98	TOTAL MEDICAID LIAB	18,516.14
		LESS: COB	0.00
		LESS: COPAYMENT	654.00
		REIMBURSEMENT	17,862.14
		TOTAL NUMBER OF CLAIMS	331

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,904.21	117.72	OTHER LAB	711.00	0.00
MED/SURG SUPPLY	743.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,521.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,036.00	2,722.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	29,937.82	4,958.58
EKG/ECG	1,419.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	11,852.70	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	46.85	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	144,090.63	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,525.67	601.25
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	104.43	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,589.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	200.00	0.00			
			TOTAL ANCILLARY	218,576.88	8,503.98
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	218,576.88	8,503.98

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 09/09/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	250,490.75	ADJUSTMENTS	14,749.37
COVERED CHARGES	231,799.25	CONTRACTUAL ALLOW	141,608.68
NON-COVERD CHARGES	18,691.50	TOTAL MEDICAID LIAB	90,190.57
		LESS: COB	490.86
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	89,699.71

TOTAL NUMBER OF ADMISSIONS 14

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	53		0	21,200.00		13,970.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	53		0	21,200.00		13,970.00
SPECIAL CARE SERVICES						
CCU	2		0	3,100.00		0.00
ICU	1		0	1,550.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	3		0	4,650.00		0.00
TOTAL ACCOMODATIONS	56		0	25,850.00		13,970.00

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 09/09/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	76,789.00	0.00	OTHER LAB	901.25	0.00
MED/SURG SUPPLY	27,639.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	29,747.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,888.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,452.00	4,721.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	975.25	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,513.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	92.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,055.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,374.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	673.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	577.25	0.00	INJECTABLE DRUGS	4,227.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	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	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	576.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	765.50	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,403.00	0.00			
AMBULATORY SURGERY	2,079.75	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,063.50	0.00			
			TOTAL ANCILLARY	205,949.25	4,721.50
			TOTAL ACCOMODATIONS	25,850.00	13,970.00
			TOTAL CHARGES	231,799.25	18,691.50

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

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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 09/09/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 09/09/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	878,617.15	ADJUSTMENTS	28,149.74
COVERED CHARGES	805,837.36	CONTRACTUAL ALLOW	610,595.16
NON-COVERD CHARGES	72,779.79	TOTAL MEDICAID LIAB	195,242.20
		LESS: COB	0.00
		LESS: COPAYMENT	1,011.00
		REIMBURSEMENT	194,231.20
		ALL OTHER	166,719.31
		FEE SCHEDULE-LAB	26,995.57
		INJECTABLE DRUGS	516.32
		TOTAL NUMBER OF CLAIMS	1,097

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 09/09/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,012.75	7.00	OTHER LAB	7,554.00	0.00
MED/SURG SUPPLY	19,188.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	12.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	73,894.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	150,012.63	14,559.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,568.00	11,157.75	FEE SCHEDULE LAB	133,325.23	36,308.54
EKG/ECG	9,339.00	628.00	MRI SERVICES	19,654.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,187.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,345.00	166.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,928.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	178,750.50	1,391.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	15,073.50	8,050.50
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	321.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,104.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,161.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,951.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	88,210.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	26,577.50	178.00			
			TOTAL ANCILLARY	805,837.36	72,779.79
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	805,837.36	72,779.79

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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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 09/09/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	310.75	ADJUSTMENTS	0.00
COVERED CHARGES	194.00	CONTRACTUAL ALLOW	50.21
NON-COVERD CHARGES	116.75	TOTAL MEDICAID LIAB	143.79
		LESS: COB	143.79
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

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 09/09/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 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	194.00	116.75
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	194.00	116.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	194.00	116.75

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 09/09/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	98,476.00	ADJUSTMENTS	485.46
COVERED CHARGES	93,735.25	CONTRACTUAL ALLOW	79,862.13
NON-COVERD CHARGES	4,740.75	TOTAL MEDICAID LIAB	13,873.12
		LESS: COB	0.00
		LESS: COPAYMENT	423.02
		REIMBURSEMENT	13,450.10
		TOTAL NUMBER OF CLAIMS	248

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 09/09/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,235.75	18.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,096.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,844.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,486.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	14,915.25	3,346.00
EKG/ECG	1,256.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	734.50	82.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	50,333.00	92.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,374.50	1,202.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	459.00	0.00			
			TOTAL ANCILLARY	93,735.25	4,740.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	93,735.25	4,740.75

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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Page: 10

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 09/09/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	09/09/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	09/09/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 00:49:47
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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 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	210,368.34	ADJUSTMENTS	0.00
COVERED CHARGES	205,547.54	CONTRACTUAL ALLOW	58,701.31
NON-COVERD CHARGES	4,820.80	TOTAL MEDICAID LIAB	146,846.23
		LESS: COB	1,267.25
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	145,578.98

TOTAL NUMBER OF ADMISSIONS 27

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	80		0	35,965.00		1,380.00
ROUTINE NURSERY	0		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	35,965.00		1,380.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	80		0	35,965.00		1,380.00

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 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,771.72	0.00	OTHER LAB	1,226.00	0.00
MED/SURG SUPPLY	11,075.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	45,405.47	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,757.55	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	726.25	3,440.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,312.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,435.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	15,800.50	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	12,451.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1.15	0.00	INJECTABLE DRUGS	32,454.90	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	759.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,258.40	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	6,246.80	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	6,901.70	0.00			
			TOTAL ANCILLARY	169,582.54	3,440.80
			TOTAL ACCOMODATIONS	35,965.00	1,380.00
			TOTAL CHARGES	205,547.54	4,820.80

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 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,406.59	ADJUSTMENTS	0.00
COVERED CHARGES	20,406.59	CONTRACTUAL ALLOW	13,829.72
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	6,576.87
		LESS: COB	6,576.87
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	6		0	2,910.00		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	2,910.00		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	2,910.00		0.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,096.40	0.00	OTHER LAB	253.00	0.00
MED/SURG SUPPLY	529.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,497.67	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,198.30	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,720.40	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	807.95	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	440.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	674.50	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	1,355.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2.30	0.00	INJECTABLE DRUGS	2,228.97	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	693.00	0.00			
			TOTAL ANCILLARY	17,496.59	0.00
			TOTAL ACCOMODATIONS	2,910.00	0.00
			TOTAL CHARGES	20,406.59	0.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 04/01/13 THROUGH 03/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	562,966.27	ADJUSTMENTS	20,784.73
COVERED CHARGES	491,320.18	CONTRACTUAL ALLOW	203,849.16
NON-COVERD CHARGES	71,646.09	TOTAL MEDICAID LIAB	287,471.02
		LESS: COB	2,017.84
		LESS: COPAYMENT	858.00
		REIMBURSEMENT	284,595.18
		ALL OTHER	248,552.63
		FEE SCHEDULE-LAB	28,494.30
		INJECTABLE DRUGS	7,548.25

TOTAL NUMBER OF CLAIMS 791

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 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,296.81	2,919.25	OTHER LAB	2,592.26	0.00
MED/SURG SUPPLY	14,743.52	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	48,958.45	3,591.60	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	33,883.65	1,720.40	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	379.50	489.50	FEE SCHEDULE LAB	178,637.96	45,902.34
EKG/ECG	12,187.10	1,600.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,991.80	925.20	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	115,369.89	1,522.75	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	18,711.19	6,445.70
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	4,095.70	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,845.25	3,233.45			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	3,123.40			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	23,660.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,967.10	172.50			
			TOTAL ANCILLARY	491,320.18	71,646.09
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	491,320.18	71,646.09

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 04/01/13 THROUGH 03/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,756.98	ADJUSTMENTS	0.00
COVERED CHARGES	1,687.98	CONTRACTUAL ALLOW	84.11
NON-COVERD CHARGES	1,069.00	TOTAL MEDICAID LIAB	1,603.87
		LESS: COB	1,597.87
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5

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 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	70.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	171.60	805.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	544.28	194.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	376.50	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	17.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	578.60	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,687.98	1,069.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,687.98	1,069.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:49:56
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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 04/01/13 THROUGH 03/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,795.91	ADJUSTMENTS	188.00
COVERED CHARGES	28,160.91	CONTRACTUAL ALLOW	23,260.91
NON-COVERD CHARGES	1,635.00	TOTAL MEDICAID LIAB	4,900.00
		LESS: COB	0.00
		LESS: COPAYMENT	186.00
		REIMBURSEMENT	4,714.00
		TOTAL NUMBER OF CLAIMS	98

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 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	922.42	35.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	380.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,149.90	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	7,043.69	1,342.00
EKG/ECG	125.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	91.30	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	17,162.50	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	1,286.00	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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	28,160.91	1,635.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	28,160.91	1,635.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:49:57
Page: 11

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	04/01/13	THROUGH	03/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:49:57
Page: 12

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 04/01/13 THROUGH 03/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,344.23	ADJUSTMENTS	0.00
COVERED CHARGES	11,954.83	CONTRACTUAL ALLOW	7,679.73
NON-COVERD CHARGES	389.40	TOTAL MEDICAID LIAB	4,275.10
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,275.10

TOTAL NUMBER OF CLAIMS 1

Report : CLM-0812-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 00:49:57
 Page: 13

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 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	170.68	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	233.15	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	568.40	177.40
EKG/ECG	125.00	125.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	80.30	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	875.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,902.30	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	11,954.83	389.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,954.83	389.40

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:49:57
Page: 14

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	04/01/13	THROUGH	03/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 00:52:02
 Page: 1

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	214,609.00	ADJUSTMENTS	0.00
COVERED CHARGES	211,890.00	CONTRACTUAL ALLOW	130,183.55
NON-COVERD CHARGES	2,719.00	TOTAL MEDICAID LIAB	81,706.45
		LESS: COB	1,562.38
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	80,144.07

TOTAL NUMBER OF ADMISSIONS 18

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	59		0	32,922.00		1,419.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	59		0	32,922.00		1,419.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	59		0	32,922.00		1,419.00

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	43,850.00	0.00	OTHER LAB	1,056.00	0.00
MED/SURG SUPPLY	5,447.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	66,869.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,165.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,217.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	708.00	0.00	MRI SERVICES	4,407.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,412.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,603.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	819.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,333.00	1,300.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,033.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	49.00	0.00			
			TOTAL ANCILLARY	178,968.00	1,300.00
			TOTAL ACCOMODATIONS	32,922.00	1,419.00
			TOTAL CHARGES	211,890.00	2,719.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:52:02
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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	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:52:03
Page: 4

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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,370,217.96	ADJUSTMENTS	17,494.94
COVERED CHARGES	1,215,036.96	CONTRACTUAL ALLOW	870,313.90
NON-COVERD CHARGES	155,181.00	TOTAL MEDICAID LIAB	344,723.06
		LESS: COB	45.04
		LESS: COPAYMENT	2,043.00
		REIMBURSEMENT	342,635.02
		ALL OTHER	283,504.58
		FEE SCHEDULE-LAB	56,025.82
		INJECTABLE DRUGS	3,104.62

TOTAL NUMBER OF CLAIMS 1,654

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	108,719.96	535.00	OTHER LAB	6,670.00	0.00
MED/SURG SUPPLY	12,124.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	91.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	132,764.00	599.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	167,503.00	25,928.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	32,484.00	14,073.00	FEE SCHEDULE LAB	436,105.00	86,226.00
EKG/ECG	4,518.00	0.00	MRI SERVICES	32,026.00	0.00
IV THERAPY	42,915.00	2,151.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	18,622.00	1,966.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	155,468.00	280.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	24,201.00	7,712.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	17,649.00	14,771.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	710.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,065.00	139.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,688.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,515.00	0.00			
			TOTAL ANCILLARY	1,215,036.96	155,181.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,215,036.96	155,181.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:52:07
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,841.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,324.00	CONTRACTUAL ALLOW	1,365.68
NON-COVERD CHARGES	10,517.00	TOTAL MEDICAID LIAB	2,958.32
		LESS: COB	2,942.98
		LESS: COPAYMENT	15.34
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 11

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	53.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	689.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	9,794.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,883.00	653.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,457.00	70.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	136.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	76.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,324.00	10,517.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,324.00	10,517.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	47,440.00	ADJUSTMENTS	47.00
COVERED CHARGES	45,779.00	CONTRACTUAL ALLOW	41,129.00
NON-COVERD CHARGES	1,661.00	TOTAL MEDICAID LIAB	4,650.00
		LESS: COB	27.30
		LESS: COPAYMENT	150.00
		REIMBURSEMENT	4,472.70
		TOTAL NUMBER OF CLAIMS	93

Report : CLM-0808-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	140.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	129.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	860.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,442.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,803.00	1,216.00
EKG/ECG	258.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,350.00	230.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	428.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,151.00	70.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,218.00	145.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	45,779.00	1,661.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	45,779.00	1,661.00

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 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	53.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	146.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	8.00
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	292.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	122.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,274.00	8.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,274.00	8.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	68,321.64	ADJUSTMENTS	0.00
COVERED CHARGES	68,321.64	CONTRACTUAL ALLOW	54,530.53
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	13,791.11
		LESS: COB	0.00
		LESS: COPAYMENT	111.00
		REIMBURSEMENT	13,680.11
		TOTAL NUMBER OF CLAIMS	3

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47,472.64	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	331.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	16,034.00	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	4,484.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	68,321.64	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	68,321.64	0.00

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF 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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,209,099.43	ADJUSTMENTS	261,696.89
COVERED CHARGES	24,968,821.05	CONTRACTUAL ALLOW	19,519,683.26
NON-COVERD CHARGES	240,278.38	TOTAL MEDICAID LIAB	5,449,137.79
		LESS: COB	81,110.67
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,368,027.12

TOTAL NUMBER OF ADMISSIONS 762

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,388		4	700,940.00		45,072.04
ROUTINE NURSERY	308		0	138,374.81		1,123.92
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		2,735.51
TOTAL ROUTINE	1,696		4	839,314.81		48,931.47
SPECIAL CARE SERVICES						
CCU	181		0	193,791.54		0.00
ICU	1,233		0	1,133,134.02		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,414		0	1,326,925.56		0.00
TOTAL ACCOMODATIONS	3,110		4	2,166,240.37		48,931.47

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,871,970.62	0.00	OTHER LAB	105,566.40	0.00
MED/SURG SUPPLY	4,970,011.09	6,780.69	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,409,520.78	0.00	EDUCATION & TRAINING	11,228.94	0.00
RADIOLOGY-DIAGNOSTIC	624,901.21	60,825.14	OTHER THERAPEUTIC SVC	0.00	9,856.25
CT SCAN	1,178,483.52	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	179,640.65	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	87,721.62	0.00	MRI SERVICES	316,396.96	0.00
IV THERAPY	294.74	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,865,759.44	0.00	DURABLE MED. EQUIP.	0.00	97.45
LABOR/DELIVERY ROOM	419,388.05	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	881,937.89	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	610,740.59	0.00	AMBULANCE	0.00	0.00
GI SERVICES	242,301.32	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,215,407.79	0.00	SPECIAL SERVICES	0.00	4,147.25
RECOVERY ROOM	94,500.85	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	158,291.21	0.00	INJECTABLE DRUGS	22,459.56	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	15,623.72	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	18,021.36	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	47,730.96	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	210.26	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	809,339.84	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	69,909.38
OTHER IMAGING SERVICE	126,331.28	1,026.07			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	126,517.03	27,133.72			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	89,690.93	11,570.96			
AUDIOLOGY	4,967.76	0.00			
CARDIOLOGY	1,221,087.07	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	55,652.34	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	20,884.90	0.00			
			TOTAL ANCILLARY	22,802,580.68	191,346.91
			TOTAL ACCOMODATIONS	2,166,240.37	48,931.47
			TOTAL CHARGES	24,968,821.05	240,278.38

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013303016396	10/05/13 - 10/19/13	11/04/13	0.00	2,762.22	0.00	0.00	0.00
615	2013330023831	11/12/13 - 11/20/13	12/02/13	0.00	6,164.16	0.00	0.00	0.00
615	2013365028843	12/18/13 - 12/24/13	01/06/14	0.00	2,762.22	0.00	0.00	0.00
615	5914002002011	12/11/13 - 12/13/13	01/06/14	0.00	2,762.22	0.00	0.00	0.00
615	2014028025333	01/13/14 - 01/15/14	02/03/14	0.00	2,762.22	0.00	0.00	0.00
615	2214066010638	12/04/13 - 12/17/13	03/10/14	0.00	5,524.44	0.00	0.00	0.00
615	2014078042631	03/06/14 - 03/10/14	03/24/14	0.00	2,762.22	0.00	0.00	0.00
615	2214092015978	02/04/14 - 02/16/14	04/07/14	0.00	2,762.22	0.00	0.00	0.00
615	2214134015299	04/22/14 - 04/24/14	05/19/14	0.00	2,762.22	0.00	0.00	0.00
615	2214142012366	02/14/14 - 02/17/14	05/26/14	0.00	2,762.22	0.00	0.00	0.00
615	2014156044542	05/27/14 - 06/01/14	06/09/14	0.00	6,164.16	0.00	0.00	0.00
615	2214164015723	01/17/14 - 01/23/14	06/16/14	0.00	2,762.22	0.00	0.00	0.00
615	2014168035996	06/04/14 - 06/07/14	06/23/14	0.00	2,872.71	0.00	0.00	0.00
615	9114167009255	03/06/14 - 03/14/14	07/07/14	0.00	2,762.22	0.00	2,398.26	0.00
615	2214241016975	02/19/14 - 02/28/14	09/01/14	0.00	6,164.16	0.00	0.00	0.00
615	2014254046009	08/28/14 - 09/01/14	09/15/14	0.00	2,872.71	0.00	0.00	0.00
615	9114251008580	06/24/14 - 07/02/14	09/22/14	0.00	2,872.71	0.00	2,517.22	0.00
615	2014261048328	09/11/14 - 09/13/14	09/22/14	0.00	2,872.71	0.00	0.00	0.00
615	2014274047749	09/20/14 - 09/22/14	10/06/14	0.00	3,906.71	0.00	0.00	0.00
615	9114321009151	07/28/14 - 08/15/14	12/15/14	0.00	2,872.71	0.00	5,887.10	0.00
TOTAL				0.00	69,909.38	0.00	10,802.58	0.00

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	338,918.07	ADJUSTMENTS	0.00
COVERED CHARGES	338,139.69	CONTRACTUAL ALLOW	255,546.56
NON-COVERD CHARGES	778.38	TOTAL MEDICAID LIAB	82,593.13
		LESS: COB	82,593.13
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 11

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	23		0	11,615.00		687.03
ROUTINE NURSERY	5		0	2,152.55		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	28		0	13,767.55		687.03
SPECIAL CARE SERVICES						
CCU	2		0	2,110.56		0.00
ICU	7		0	5,490.59		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	7,601.15		0.00
TOTAL ACCOMODATIONS	37		0	21,368.70		687.03

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	49,550.64	0.00	OTHER LAB	580.32	0.00
MED/SURG SUPPLY	49,833.33	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	19,523.65	0.00	EDUCATION & TRAINING	61.96	0.00
RADIOLOGY-DIAGNOSTIC	15,343.59	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,068.61	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	159.26	0.00	MRI SERVICES	1,437.63	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	104,749.90	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	17,827.51	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,574.93	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,854.12	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,055.42	0.00	SPECIAL SERVICES	0.00	91.35
RECOVERY ROOM	1,311.93	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,065.10	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	34,813.20	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	680.36	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	84.00	0.00			
CARDIOLOGY	4,195.53	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	316,770.99	91.35
			TOTAL ACCOMODATIONS	21,368.70	687.03
			TOTAL CHARGES	338,139.69	778.38

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:52:22
Page: 6

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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,494,434.12	ADJUSTMENTS	1,291,678.85
COVERED CHARGES	22,286,229.07	CONTRACTUAL ALLOW	18,929,829.57
NON-COVERD CHARGES	3,208,205.05	TOTAL MEDICAID LIAB	3,356,399.50
		LESS: COB	1,966.55
		LESS: COPAYMENT	7,135.14
		REIMBURSEMENT	3,347,297.81
		ALL OTHER	3,153,578.65
		FEE SCHEDULE-LAB	169,663.55
		INJECTABLE DRUGS	24,055.61

TOTAL NUMBER OF CLAIMS 5,879

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55,446.13	208,157.25	OTHER LAB	526,007.82	16,151.97
MED/SURG SUPPLY	2,911,565.49	19,626.64	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	412.66	654.15
RADIOLOGY-DIAGNOSTIC	986,070.36	45,221.40	OTHER THERAPEUTIC SVC	0.00	7,796.64
CT SCAN	2,362,900.60	203,506.94	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	431.88	9,719.18	FEE SCHEDULE LAB	2,937,560.90	746,643.45
EKG/ECG	104,707.57	6,141.06	MRI SERVICES	745,157.20	45,369.21
IV THERAPY	26,732.95	2,179.66	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,672,074.91	540,368.78	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,083.44	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	394,168.17	35,790.52	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	612,012.17	17,883.29	AMBULANCE	0.00	0.00
GI SERVICES	176,051.51	46,823.39	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,096,345.64	102,400.58	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	280,701.18	1,772.43	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	516,327.20	276,517.32
RADIOLOGY THERAPEUTIC	379.64	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,602.50	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,636.10	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	6,899.63	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	63,284.89	301,932.37
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	634,292.79	81,242.35			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	16,163.34	1,366.37			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	206,513.36	58,986.91			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,380,636.52	355,445.13			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	35,971.86	2,972.88			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	543,228.89	62,396.95			
			TOTAL ANCILLARY	22,286,229.07	3,208,205.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	22,286,229.07	3,208,205.05

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	834,646.82	ADJUSTMENTS	0.00
COVERED CHARGES	691,605.42	CONTRACTUAL ALLOW	374,432.78
NON-COVERD CHARGES	143,041.40	TOTAL MEDICAID LIAB	317,172.64
		LESS: COB	317,110.27
		LESS: COPAYMENT	62.37
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 155

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,963.57	8,951.20	OTHER LAB	28,488.32	1,015.06
MED/SURG SUPPLY	162,176.17	926.68	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,829.51	1,509.07	OTHER THERAPEUTIC SVC	0.00	3,473.71
CT SCAN	4,533.97	35,509.16	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	296.49	FEE SCHEDULE LAB	108,782.04	21,224.91
EKG/ECG	1,777.34	159.26	MRI SERVICES	22,273.78	14,931.76
IV THERAPY	947.48	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	55,931.46	7,779.55	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	406.60	406.60	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	44,548.99	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	7,504.52	CAST ROOM	0.00	0.00
EMERGENCY ROOM	151,492.43	161.68	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	29,103.11	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	25,513.67	16,138.47
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	396.65	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,822.66	17,644.66			
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	8,558.88	1,646.49			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,972.88	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,482.56	3,365.48			
			TOTAL ANCILLARY	691,605.42	143,041.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	691,605.42	143,041.40

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,584,724.99	ADJUSTMENTS	4,677.76
COVERED CHARGES	2,386,279.83	CONTRACTUAL ALLOW	2,333,080.92
NON-COVERD CHARGES	198,445.16	TOTAL MEDICAID LIAB	53,198.91
		LESS: COB	0.00
		LESS: COPAYMENT	1,569.01
		REIMBURSEMENT	51,629.90

TOTAL NUMBER OF CLAIMS 951

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,807.09	30,344.14	OTHER LAB	30,934.75	4,100.84
MED/SURG SUPPLY	118,369.73	2,409.07	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	109,094.95	673.37	OTHER THERAPEUTIC SVC	0.00	1,837.73
CT SCAN	203,138.98	38,362.86	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	296.48	FEE SCHEDULE LAB	341,104.94	48,069.14
EKG/ECG	10,759.60	159.26	MRI SERVICES	7,447.57	0.00
IV THERAPY	30.67	61.34	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,366.27	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,076.07	2,915.23	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,705.66	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,440,279.34	14,988.96	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,947.05	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	44,105.00	32,574.35
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	878.70	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	210.26	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	598.56	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	44,738.01	18,565.09			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,547.78	268.97			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	978.40			
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	7,227.81	750.97			
			TOTAL ANCILLARY	2,386,279.83	198,445.16
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,386,279.83	198,445.16

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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Page: 12

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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	117,995.59	ADJUSTMENTS	0.00
COVERED CHARGES	102,122.27	CONTRACTUAL ALLOW	61,331.32
NON-COVERD CHARGES	15,873.32	TOTAL MEDICAID LIAB	40,790.95
		LESS: COB	40,751.95
		LESS: COPAYMENT	39.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 35

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	1,326.03	OTHER LAB	3,045.18	1,015.06
MED/SURG SUPPLY	5,146.41	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,895.26	0.00	OTHER THERAPEUTIC SVC	0.00	152.82
CT SCAN	0.00	4,416.81	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,800.44	2,666.55
EKG/ECG	637.04	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	62,763.84	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,767.86	1,888.75
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	3,066.24	4,407.30			
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	0.00	0.00			
			TOTAL ANCILLARY	102,122.27	15,873.32
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	102,122.27	15,873.32

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,260,607.20	ADJUSTMENTS	274,209.45
COVERED CHARGES	5,618,688.92	CONTRACTUAL ALLOW	5,080,700.56
NON-COVERD CHARGES	641,918.28	TOTAL MEDICAID LIAB	537,988.36
		LESS: COB	0.00
		LESS: COPAYMENT	522.00
		REIMBURSEMENT	537,466.36
		TOTAL NUMBER OF CLAIMS	100

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EAST GA REGIONAL MEDICAL CTR., LLC	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
1499 FAIR RD	000000272A	SERVICE DATES	10/01/13	THROUGH	09/30/14
STATESBORO,GA 30458-1683		ADMISSION DATES	00/00/00	THROUGH	00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,875.96	64,686.75	OTHER LAB	687.43	0.00
MED/SURG SUPPLY	1,614,946.77	1,223.24	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,885.66	1,556.95	OTHER THERAPEUTIC SVC	0.00	1,670.17
CT SCAN	24,164.02	3,832.90	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	110,233.44	28,448.01
EKG/ECG	6,924.62	2,414.38	MRI SERVICES	3,041.10	4,090.88
IV THERAPY	613.82	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,113,931.42	189,642.19	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,426.76	102.64	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	356,237.44	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,303.82	1,036.36	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	139,886.33	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	89,015.88	61,460.13
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,577.72	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	692,258.19	125,243.46
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,439.78	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,547.78	268.97			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,037.03	1,372.61			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	405,370.14	151,776.10			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,486.44	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,375.09	1,514.82			
			TOTAL ANCILLARY	5,618,688.92	641,918.28
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,618,688.92	641,918.28

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	206,546.30	ADJUSTMENTS	0.00
COVERED CHARGES	206,017.71	CONTRACTUAL ALLOW	109,999.68
NON-COVERD CHARGES	528.59	TOTAL MEDICAID LIAB	96,018.03
		LESS: COB	96,012.03
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

Report : CLM-0814-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,243.26	164.16	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,152.93	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	460.18	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	626.28	11.80
EKG/ECG	159.26	159.26	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	92,040.03	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	244.23	103.57	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,421.38	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	881.53	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	873.31	89.80
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	94,915.32	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	206,017.71	528.59
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	206,017.71	528.59

** END OF 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 06/01/13 THROUGH 05/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	477,543.47	ADJUSTMENTS	0.00
COVERED CHARGES	472,312.22	CONTRACTUAL ALLOW	259,578.51
NON-COVERD CHARGES	5,231.25	TOTAL MEDICAID LIAB	212,733.71
		LESS: COB	1,750.07
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	210,983.64

TOTAL NUMBER OF ADMISSIONS 36

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	137		0	43,840.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	137		0	43,840.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	137		0	43,840.00		0.00

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 06/01/13 THROUGH 05/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	101,268.90	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	61,369.76	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	63,201.40	0.00	EDUCATION & TRAINING	536.00	0.00
RADIOLOGY-DIAGNOSTIC	12,826.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,111.75	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	326.25	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,154.50	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	78,991.06	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	754.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,317.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	43,957.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	169.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	326.25	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	202.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	941.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	22,333.60	5,231.25			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,100.50	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	5,584.75	0.00			
			TOTAL ANCILLARY	428,472.22	5,231.25
			TOTAL ACCOMODATIONS	43,840.00	0.00
			TOTAL CHARGES	472,312.22	5,231.25

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

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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	06/01/13	THROUGH	05/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:53:05
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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 06/01/13 THROUGH 05/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,119,144.58	ADJUSTMENTS	46,677.18
COVERED CHARGES	1,006,308.93	CONTRACTUAL ALLOW	594,499.93
NON-COVERD CHARGES	112,835.65	TOTAL MEDICAID LIAB	411,809.00
		LESS: COB	0.00
		LESS: COPAYMENT	846.00
		REIMBURSEMENT	410,963.00
		ALL OTHER	390,553.63
		FEE SCHEDULE-LAB	19,910.25
		INJECTABLE DRUGS	499.12
		TOTAL NUMBER OF CLAIMS	1,108

Report : CLM-0804-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 00:53:05
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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 06/01/13 THROUGH 05/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	61,925.50	2,628.15	OTHER LAB	4,517.25	0.00
MED/SURG SUPPLY	46,721.51	443.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	51,079.25	1,156.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	98,146.75	6,636.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	133,321.05	49,602.50
EKG/ECG	13,685.00	612.50	MRI SERVICES	0.00	0.00
IV THERAPY	50,765.25	10,062.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,844.32	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	15,092.31	9,741.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,313.90	0.00	AMBULANCE	0.00	0.00
GI SERVICES	28,349.50	16,067.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	320,946.26	6,716.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,746.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,818.18	1,117.50
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	16,574.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	62,386.50	290.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,612.15	1,185.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,858.00	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	47,606.25	6,575.00			
			TOTAL ANCILLARY	1,006,308.93	112,835.65
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,006,308.93	112,835.65

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 06/01/13 THROUGH 05/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,011.15	ADJUSTMENTS	0.00
COVERED CHARGES	4,244.15	CONTRACTUAL ALLOW	4,098.55
NON-COVERD CHARGES	767.00	TOTAL MEDICAID LIAB	145.60
		LESS: COB	145.60
		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

Report : CLM-0806-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 00:53:10
 Page: 7

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 06/01/13 THROUGH 05/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	91.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	67.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	464.50	409.50
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	1,118.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	290.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,524.25	0.00			
			TOTAL ANCILLARY	4,244.15	767.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,244.15	767.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:53:10
Page: 8

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 06/01/13 THROUGH 05/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	72,125.05	ADJUSTMENTS	105.88
COVERED CHARGES	70,309.80	CONTRACTUAL ALLOW	63,149.48
NON-COVERD CHARGES	1,815.25	TOTAL MEDICAID LIAB	7,160.32
		LESS: COB	0.00
		LESS: COPAYMENT	243.00
		REIMBURSEMENT	6,917.32
		TOTAL NUMBER OF CLAIMS	128

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 06/01/13 THROUGH 05/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,752.00	32.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,033.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,758.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,750.75	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,362.25	1,394.75
EKG/ECG	226.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,613.00	153.50	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	268.75	143.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	49,489.25	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	336.50	92.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	170.25	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	549.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	70,309.80	1,815.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	70,309.80	1,815.25

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	06/01/13	THROUGH	05/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	06/01/13	THROUGH	05/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	06/01/13	THROUGH	05/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF 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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	71,551,505.80	ADJUSTMENTS	3,677,837.47
COVERED CHARGES	66,188,498.70	CONTRACTUAL ALLOW	42,617,812.12
NON-COVERD CHARGES	5,363,007.10	TOTAL MEDICAID LIAB	23,570,686.58
		LESS: COB	250,118.19
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	23,320,568.39

TOTAL NUMBER OF ADMISSIONS 3,425

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	8,360	64	8,524,350.00	4,729,027.60
ROUTINE NURSERY	2,253	14	2,168,312.00	10,807.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	10,613	78	10,692,662.00	4,739,834.60
SPECIAL CARE SERVICES				
CCU	120	0	465,900.00	0.00
ICU	1,850	0	5,133,691.00	3,705.00
NICU	1,776	0	4,944,481.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	3,746	0	10,544,072.00	3,705.00
TOTAL ACCOMODATIONS	14,359	78	21,236,734.00	4,743,539.60

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,375,662.33	16,980.50	OTHER LAB	610,990.00	3,153.00
MED/SURG SUPPLY	328,203.92	85,918.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,771,232.36	22,712.00	EDUCATION & TRAINING	11,510.00	140.00
RADIOLOGY-DIAGNOSTIC	1,963,293.00	5,263.00	OTHER THERAPEUTIC SVC	0.00	4,719.00
CT SCAN	3,361,026.00	158,077.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	348,800.08	8,515.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	521,385.00	375.00	MRI SERVICES	783,704.00	2,959.00
IV THERAPY	56,274.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,208,437.50	23,260.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	327,997.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,120,967.50	11,028.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,242,265.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	290,095.00	1,354.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,927,853.00	23,505.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,736,979.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	525,662.00	0.00	INJECTABLE DRUGS	3,140,518.99	7,704.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	102,888.00	2,154.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	83,044.02	2,588.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	606,294.00	32,685.00	PATIENT CONVENIENCE	0.00	842.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	236.00	0.00	TRAUMA RESPONSE	0.00	60,080.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,756,438.00	1,114.00
LITHOTRIpsy	20,000.00	0.00	NO CC/INVALID REV CODE	0.00	115,302.00
OTHER IMAGING SERVICE	443,904.00	447.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	455,815.00	28,593.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	427,163.00	0.00			
AUDIOLOGY	73,982.00	0.00			
CARDIOLOGY	1,871,633.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	125,690.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	331,821.00	0.00			
			TOTAL ANCILLARY	44,951,764.70	619,467.50
			TOTAL ACCOMODATIONS	21,236,734.00	4,743,539.60
			TOTAL CHARGES	66,188,498.70	5,363,007.10

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2213266001199	08/21/13 - 08/23/13	09/30/13	0.00	2,363.00	0.00	0.00	0.00
615	2313315000142	08/18/13 - 08/21/13	12/09/13	0.00	2,363.00	0.00	0.00	0.00
615	2013330052517	08/22/13 - 08/28/13	12/02/13	0.00	2,363.00	0.00	0.00	0.00
615	2213338000785	09/18/13 - 10/29/13	12/09/13	0.00	2,363.00	0.00	0.00	0.00
618	2013344062453	11/23/13 - 11/24/13	12/16/13	0.00	2,822.00	0.00	0.00	0.00
615	2014009067982	08/03/13 - 08/07/13	01/13/14	0.00	2,363.00	0.00	0.00	0.00
615	2014036092148	01/06/14 - 01/09/14	02/10/14	0.00	2,363.00	0.00	0.00	0.00
615	2014036092158	09/20/13 - 09/29/13	02/10/14	0.00	2,363.00	0.00	0.00	0.00
615	2314056000005	10/30/13 - 11/06/13	03/31/14	0.00	4,348.00	0.00	0.00	0.00
615	2014063044001	10/06/13 - 10/07/13	03/10/14	0.00	2,363.00	0.00	0.00	0.00
615	2314080000015	08/12/13 - 09/03/13	04/28/14	0.00	4,348.00	0.00	0.00	0.00
615	2014093091969	10/29/13 - 11/04/13	04/07/14	0.00	4,348.00	0.00	0.00	0.00
615	5214104000131	08/02/13 - 08/26/13	04/21/14	0.00	4,348.00	0.00	0.00	0.00
615	2214136001448	10/05/13 - 11/20/13	05/19/14	0.00	2,363.00	0.00	0.00	0.00
615	2214161000347	10/01/13 - 10/03/13	06/16/14	0.00	2,363.00	0.00	0.00	0.00
615	9714170966085	02/24/14 - 02/27/14	06/23/14	0.00	4,348.00	0.00	0.00	0.00
615	5214188000774	09/03/13 - 09/18/13	07/14/14	0.00	4,348.00	0.00	0.00	0.00
615	2014196051704	06/29/14 - 07/04/14	07/21/14	0.00	2,363.00	0.00	0.00	0.00
615	2014239067842	10/09/13 - 11/01/13	09/01/14	0.00	4,348.00	0.00	0.00	0.00
615	2314252000059	05/21/14 - 05/27/14	09/22/14	0.00	2,363.00	0.00	0.00	0.00
615	2014253094863	09/29/13 - 11/27/13	09/15/14	0.00	2,363.00	0.00	0.00	0.00
615	9114251008609	02/24/14 - 03/01/14	09/22/14	0.00	4,348.00	0.00	2,124.81	0.00
615	5214258000283	10/17/13 - 01/24/14	09/22/14	0.00	1,985.00	0.00	0.00	0.00
615	9114253003406	01/23/14 - 02/20/14	09/22/14	0.00	4,348.00	0.00	6,191.49	0.00
615	2314260000078	05/19/14 - 05/28/14	09/29/14	0.00	2,363.00	0.00	0.00	0.00
615	2014268003546	12/25/13 - 12/31/13	09/29/14	0.00	4,348.00	0.00	0.00	0.00
615	2314280000064	05/28/14 - 06/09/14	10/20/14	0.00	2,363.00	0.00	0.00	0.00
615	2014282092402	02/13/14 - 02/19/14	10/13/14	0.00	4,348.00	0.00	0.00	0.00
615	5214287000019	04/18/14 - 05/08/14	10/20/14	0.00	4,348.00	0.00	0.00	0.00
615	2014295079346	01/15/14 - 01/18/14	10/27/14	0.00	2,363.00	0.00	0.00	0.00
615	2014309002057	05/07/14 - 05/23/14	11/10/14	0.00	4,348.00	0.00	0.00	0.00
615	5214310000126	11/29/13 - 01/01/14	11/10/14	0.00	2,363.00	0.00	0.00	0.00
615	2014330067492	06/07/14 - 06/11/14	12/01/14	0.00	2,363.00	0.00	0.00	0.00
615	5215051000025	02/10/14 - 03/02/14	03/02/15	0.00	2,363.00	0.00	2,818.11	0.00
615	5215051000026	02/01/14 - 02/22/14	03/02/15	0.00	4,348.00	0.00	0.00	0.00
615	2015054034619	10/21/13 - 10/24/13	03/02/15	0.00	2,363.00	0.00	0.00	0.00
615	2215110005222	04/11/14 - 09/23/14	04/27/15	0.00	2,363.00	0.00	0.00	0.00
TOTAL				0.00	115,302.00	0.00	11,134.41	0.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	61,201.96	ADJUSTMENTS	0.00
COVERED CHARGES	55,672.96	CONTRACTUAL ALLOW	18,683.81
NON-COVERD CHARGES	5,529.00	TOTAL MEDICAID LIAB	36,989.15
		LESS: COB	36,989.15
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 7

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	11		2	11,374.00		5,529.00
ROUTINE NURSERY	4		0	3,837.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	15		2	15,211.00		5,529.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	2		0	5,550.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	5,550.00		0.00
TOTAL ACCOMODATIONS	17		2	20,761.00		5,529.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,646.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	195.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,714.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,381.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,312.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	82.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,291.00	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	5,075.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,214.00	0.00	INJECTABLE DRUGS	4,643.96	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,117.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	23.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	207.00	0.00			
CARDIOLOGY	1,750.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,255.00	0.00			
			TOTAL ANCILLARY	34,911.96	0.00
			TOTAL ACCOMODATIONS	20,761.00	5,529.00
			TOTAL CHARGES	55,672.96	5,529.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:53:39
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	30,531,603.06	ADJUSTMENTS	767,856.72
COVERED CHARGES	27,178,830.63	CONTRACTUAL ALLOW	21,677,303.20
NON-COVERD CHARGES	3,352,772.43	TOTAL MEDICAID LIAB	5,501,527.43
		LESS: COB	14,114.13
		LESS: COPAYMENT	13,061.02
		REIMBURSEMENT	5,474,352.28
		ALL OTHER	4,306,197.86
		FEE SCHEDULE-LAB	312,759.82
		INJECTABLE DRUGS	855,394.60

TOTAL NUMBER OF CLAIMS 10,742

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	627,759.00	96,448.00	OTHER LAB	309,232.00	0.00
MED/SURG SUPPLY	63,903.00	14,019.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	4,482.00	EDUCATION & TRAINING	0.00	770.00
RADIOLOGY-DIAGNOSTIC	1,451,263.00	25,598.00	OTHER THERAPEUTIC SVC	0.00	33,075.00
CT SCAN	2,823,986.00	430,420.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	33,520.00	7,375.00	FEE SCHEDULE LAB	2,952,737.00	455,920.50
EKG/ECG	455,170.00	13,875.00	MRI SERVICES	476,685.00	71,544.00
IV THERAPY	726,729.00	86,130.00	PROFESSIONAL FEES	0.00	143.00
OPERATING ROOM	2,138,454.93	272,546.83	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,532.00	0.00	REHAB THERAPY	377.00	0.00
RESPIRATORY SERVICES	94,782.00	40,214.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	517,819.00	3,844.00	AMBULANCE	0.00	0.00
GI SERVICES	188,919.00	10,741.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,628,158.50	90,204.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	689,078.00	3,508.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	1,006.00	INJECTABLE DRUGS	4,318,336.20	368,686.03
RADIOLOGY THERAPEUTIC	36,791.00	313.00	HOME HEALTH SERVICES	0.00	184.00
OCCUPATIONAL THERAPY	15,685.00	10,148.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,108.00	3,805.07	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	152,826.00	PATIENT CONVENIENCE	0.00	16.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	85,831.00	2,763.00	TRAUMA RESPONSE	0.00	24,032.00
PSYCHIATRIC SERVICES	377.00	0.00	IMPL DEV CHARGE PATIENTS	51,065.00	642,741.00
LITHOTRIPSY	0.00	20,000.00	NO CC/INVALID REV CODE	0.00	19,512.00
OTHER IMAGING SERVICE	1,236,586.00	123,247.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	81,134.00	13,398.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	744,537.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	836,236.00	292,344.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,844.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	585,196.00	16,862.00			
			TOTAL ANCILLARY	27,178,830.63	3,352,740.43
			TOTAL ACCOMODATIONS	0.00	32.00
			TOTAL CHARGES	27,178,830.63	3,352,772.43

Report : CLM-0804-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
618	2213238007486	07/30/13 - 07/30/13	09/02/13	0.00	2,732.00	0.00	0.00	0.00
615	2013266062175	08/16/13 - 08/16/13	09/30/13	0.00	2,363.00	0.00	0.00	0.00
951	2013351058194	12/02/13 - 12/02/13	12/23/13	0.00	60.00	0.00	0.00	0.00
951	2013354069135	12/12/13 - 12/12/13	12/30/13	0.00	120.00	0.00	0.00	0.00
615	2014008060734	09/29/13 - 09/29/13	01/13/14	0.00	2,363.00	0.00	0.00	0.00
615	2014008060734	09/29/13 - 09/29/13	01/13/14	0.00	1,985.00	0.00	0.00	0.00
951	2014030058345	01/22/14 - 01/22/14	02/03/14	0.00	130.00	0.00	0.00	0.00
951	2014048033096	01/17/14 - 01/17/14	02/24/14	0.00	60.00	0.00	0.00	0.00
951	2014048033096	01/17/14 - 01/17/14	02/24/14	0.00	130.00	0.00	0.00	0.00
615	2214106009383	03/10/14 - 03/10/14	04/21/14	0.00	2,363.00	0.00	0.00	0.00
9928	2214189009881	02/04/14 - 02/04/14	07/14/14	0.00	1,955.00	0.00	0.00	0.00
615	2214259005993	06/23/14 - 06/23/14	09/22/14	0.00	2,363.00	0.00	0.00	0.00
615	2214259005993	06/23/14 - 06/23/14	09/22/14	0.00	2,610.00	0.00	0.00	0.00
22	5914265000220	05/29/14 - 05/29/14	09/29/14	0.00	119.00	0.00	0.00	0.00
22	5914265000220	05/29/14 - 05/29/14	09/29/14	0.00	81.00	0.00	0.00	0.00
22	5914265000220	05/29/14 - 05/29/14	09/29/14	0.00	78.00	0.00	0.00	0.00
TOTAL				0.00	19,512.00	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	333,362.00	ADJUSTMENTS	0.00
COVERED CHARGES	280,617.00	CONTRACTUAL ALLOW	200,331.98
NON-COVERD CHARGES	52,745.00	TOTAL MEDICAID LIAB	80,285.02
		LESS: COB	80,146.56
		LESS: COPAYMENT	138.46
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 106

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,939.00	200.00	OTHER LAB	1,555.00	0.00
MED/SURG SUPPLY	781.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,006.00	301.00	OTHER THERAPEUTIC SVC	0.00	484.00
CT SCAN	14,833.00	11,401.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	446.00	0.00	FEE SCHEDULE LAB	25,839.00	4,874.00
EKG/ECG	3,750.00	0.00	MRI SERVICES	28,522.00	0.00
IV THERAPY	11,810.00	725.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	28,571.00	4,170.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,278.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	50,767.00	219.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,041.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	54,551.00	21,590.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	532.00	1,462.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	183.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,071.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	3,462.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,423.00	2,302.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	726.00	957.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,144.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,849.00	556.00			
			TOTAL ANCILLARY	280,617.00	52,703.00
			TOTAL ACCOMODATIONS	0.00	42.00
			TOTAL CHARGES	280,617.00	52,745.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	856,313.00	ADJUSTMENTS	535.40
COVERED CHARGES	810,739.00	CONTRACTUAL ALLOW	770,294.38
NON-COVERD CHARGES	45,574.00	TOTAL MEDICAID LIAB	40,444.62
		LESS: COB	64.64
		LESS: COPAYMENT	861.01
		REIMBURSEMENT	39,518.97
		TOTAL NUMBER OF CLAIMS	723

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,911.00	2,000.00	OTHER LAB	13,840.00	0.00
MED/SURG SUPPLY	871.00	738.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	59,958.00	0.00	OTHER THERAPEUTIC SVC	0.00	242.00
CT SCAN	33,718.00	8,773.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	99,880.00	12,775.00
EKG/ECG	10,875.00	0.00	MRI SERVICES	9,206.00	6,287.00
IV THERAPY	1,019.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	1,130.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,727.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	536,627.00	3,456.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,976.00	3,289.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	868.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	17,200.00	4,717.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,931.00	1,299.00			
			TOTAL ANCILLARY	810,739.00	45,574.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	810,739.00	45,574.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:54:24
Page: 13

WINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,953.00	ADJUSTMENTS	0.00
COVERED CHARGES	18,693.00	CONTRACTUAL ALLOW	12,988.53
NON-COVERD CHARGES	260.00	TOTAL MEDICAID LIAB	5,704.47
		LESS: COB	5,689.47
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	513.00	0.00	OTHER LAB	1,555.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,926.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,518.00	260.00
EKG/ECG	1,125.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,056.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPTY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	18,693.00	260.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,693.00	260.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,463,970.60	ADJUSTMENTS	241,651.96
COVERED CHARGES	3,361,424.40	CONTRACTUAL ALLOW	2,655,557.89
NON-COVERD CHARGES	102,546.20	TOTAL MEDICAID LIAB	705,866.51
		LESS: COB	0.00
		LESS: COPAYMENT	589.68
		REIMBURSEMENT	705,276.83
		TOTAL NUMBER OF CLAIMS	130

Report : CLM-0812-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	66,713.00	6,300.00	OTHER LAB	949.00	0.00
MED/SURG SUPPLY	3,922.00	1,502.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	140.00
RADIOLOGY-DIAGNOSTIC	36,088.00	1,450.00	OTHER THERAPEUTIC SVC	0.00	726.00
CT SCAN	32,148.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	862.00	FEE SCHEDULE LAB	87,124.80	11,486.20
EKG/ECG	6,375.00	3,375.00	MRI SERVICES	6,435.00	3,600.00
IV THERAPY	117,574.00	4,792.00	PROFESSIONAL FEES	0.00	139.00
OPERATING ROOM	600,765.00	3,980.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	551.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	164,051.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	36,143.00	3,593.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	187,046.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,310,490.60	27,763.00
RADIOLOGY THERAPEUTIC	8,216.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	45,293.00	21,163.00
LITHOTRIPSY	531,740.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,881.00	363.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	20,871.00	957.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	16,695.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	48,582.00	10,355.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	630.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	27,141.00	0.00			
			TOTAL ANCILLARY	3,361,424.40	102,546.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,361,424.40	102,546.20

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	36,994.00	ADJUSTMENTS	0.00
COVERED CHARGES	32,590.00	CONTRACTUAL ALLOW	22,974.24
NON-COVERD CHARGES	4,404.00	TOTAL MEDICAID LIAB	9,615.76
		LESS: COB	9,612.76
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

Report : CLM-0814-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,108.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	345.00	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	184.00	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	25,243.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	1,111.00	236.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,522.00	4,168.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,077.00	0.00			
			TOTAL ANCILLARY	32,590.00	4,404.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	32,590.00	4,404.00

** END OF 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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	948,551.64	ADJUSTMENTS	3,597.99
COVERED CHARGES	917,783.89	CONTRACTUAL ALLOW	589,533.73
NON-COVERD CHARGES	30,767.75	TOTAL MEDICAID LIAB	328,250.16
		LESS: COB	597.71
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	327,652.45

TOTAL NUMBER OF ADMISSIONS 50

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	138		2	118,818.00		30,082.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	138		2	118,818.00		30,082.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	52		0	104,572.00		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	52		0	104,572.00		0.00
TOTAL ACCOMODATIONS	190		2	223,390.00		30,082.00

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	93,246.47	0.00	OTHER LAB	894.00	0.00
MED/SURG SUPPLY	47,543.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	176,394.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	27,702.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	77,342.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,829.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,231.00	0.00	MRI SERVICES	3,352.00	0.00
IV THERAPY	250.00	617.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,461.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	93,509.04	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,428.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	75,388.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,676.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	9,387.00	0.00	INJECTABLE DRUGS	33,542.13	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	672.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,012.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	68.00
OTHER IMAGING SERVICE	11,495.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,680.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	360.00	0.00			
			TOTAL ANCILLARY	694,393.89	685.75
			TOTAL ACCOMODATIONS	223,390.00	30,082.00
			TOTAL CHARGES	917,783.89	30,767.75

Report : CLM-0800-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3047	2214297005947	10/08/14 - 10/13/14	10/27/14	0.00	68.00	0.00	0.00	0.00
TOTAL				0.00	68.00	0.00	0.00	0.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

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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	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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CANDLER COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,760,418.51	ADJUSTMENTS	42,867.86
COVERED CHARGES	2,266,648.43	CONTRACTUAL ALLOW	1,854,564.63
NON-COVERD CHARGES	493,770.08	TOTAL MEDICAID LIAB	412,083.80
		LESS: COB	290.71
		LESS: COPAYMENT	1,998.00
		REIMBURSEMENT	409,795.09
		ALL OTHER	375,969.21
		FEE SCHEDULE-LAB	32,236.43
		INJECTABLE DRUGS	1,589.45
		TOTAL NUMBER OF CLAIMS	1,296

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

PROVIDER NUMBER
 000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,946.83	8,261.57	OTHER LAB	6,594.00	447.00
MED/SURG SUPPLY	140,213.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	216.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	143,469.00	4,712.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	287,922.00	93,651.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,842.00	9,582.02	FEE SCHEDULE LAB	461,682.60	95,523.50
EKG/ECG	60,105.00	875.00	MRI SERVICES	75,276.00	7,375.00
IV THERAPY	0.00	276.00	PROFESSIONAL FEES	0.00	4,648.00
OPERATING ROOM	355,115.25	182,507.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	16,160.00	4,387.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	45,574.00	24,330.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	393,722.00	12,636.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	149,576.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	25,577.15	13,438.84
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	1,955.15	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	7,152.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	3,352.00
OTHER IMAGING SERVICE	40,237.00	9,135.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,680.00	670.00			
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	9,440.00	8,640.00			
			TOTAL ANCILLARY	2,266,648.43	493,770.08
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,266,648.43	493,770.08

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:54:43
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CANDLER COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014197039695	07/11/14 - 07/11/14	07/21/14	0.00	3,352.00	0.00	0.00	0.00
TOTAL				0.00	3,352.00	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:54:47
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	672.00	ADJUSTMENTS	0.00
COVERED CHARGES	672.00	CONTRACTUAL ALLOW	431.04
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	240.96
		LESS: COB	240.96
		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

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 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	672.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	672.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	672.00	0.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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CANDLER COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	170,552.63	ADJUSTMENTS	238.00
COVERED CHARGES	164,080.06	CONTRACTUAL ALLOW	156,280.06
NON-COVERD CHARGES	6,472.57	TOTAL MEDICAID LIAB	7,800.00
		LESS: COB	0.00
		LESS: COPAYMENT	300.00
		REIMBURSEMENT	7,500.00
		TOTAL NUMBER OF CLAIMS	156

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,603.50	67.75	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,886.00	31.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	113.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,970.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,124.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	33,730.00	4,066.00
EKG/ECG	2,092.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	276.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	79.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	94,672.00	996.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,923.56	922.82
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	164,080.06	6,472.57
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	164,080.06	6,472.57

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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

PROVIDER NUMBER
000000316A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

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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	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,432,035.19	ADJUSTMENTS	985,066.19
COVERED CHARGES	29,057,965.10	CONTRACTUAL ALLOW	21,452,749.14
NON-COVERD CHARGES	374,070.09	TOTAL MEDICAID LIAB	7,605,215.96
		LESS: COB	121,417.60
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,483,798.36

TOTAL NUMBER OF ADMISSIONS 876

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,356		0	2,936,500.00		0.00
ROUTINE NURSERY	535		0	509,215.00		10,355.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,891		0	3,445,715.00		10,355.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,607		0	3,083,483.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,607		0	3,083,483.00		0.00
TOTAL ACCOMODATIONS	5,498		0	6,529,198.00		10,355.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,247,637.77	7,057.00	OTHER LAB	80,465.00	0.00
MED/SURG SUPPLY	936,454.38	12,757.09	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,270,006.00	23,875.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,207,933.00	0.00	OTHER THERAPEUTIC SVC	0.00	43,085.00
CT SCAN	1,169,908.00	38,521.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	237,103.07	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	76,605.00	0.00	MRI SERVICES	248,925.00	0.00
IV THERAPY	219,496.00	3,036.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,007,498.00	48,644.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	628,335.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,314,272.00	7.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	544,235.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	158,908.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	519,579.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	258,358.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	162,067.00	0.00	INJECTABLE DRUGS	4,138,555.92	0.00
RADIOLOGY THERAPEUTIC	114,914.00	4,342.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	75,863.41	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	84,868.55	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	151,840.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	256,905.00	0.00
LITHOTRIPSY	23,753.00	0.00	NO CC/INVALID REV CODE	0.00	245.00
OTHER IMAGING SERVICE	157,298.00	7,270.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	911,702.00	119,738.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	69,466.00	55,138.00			
AUDIOLOGY	354.00	0.00			
CARDIOLOGY	152,359.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	35,664.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	67,439.00	0.00			
			TOTAL ANCILLARY	22,528,767.10	363,715.09
			TOTAL ACCOMODATIONS	6,529,198.00	10,355.00
			TOTAL CHARGES	29,057,965.10	374,070.09

Report : CLM-0800-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:54:55
Page: 3

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014097025653	12/11/13 - 12/13/13	04/14/14	0.00	245.00	0.00	0.00	0.00
TOTAL				0.00	245.00	0.00	0.00	0.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	119,148.00	ADJUSTMENTS	0.00
COVERED CHARGES	119,148.00	CONTRACTUAL ALLOW	62,110.17
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	57,037.83
		LESS: COB	57,037.83
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 13

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	29		0	25,375.00		0.00
ROUTINE NURSERY	5		0	2,550.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	34		0	27,925.00		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	34		0	27,925.00		0.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,854.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	392.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,704.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	51,318.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	133.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,312.00	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	1,472.00	0.00	INJECTABLE DRUGS	7,038.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	91,223.00	0.00
			TOTAL ACCOMODATIONS	27,925.00	0.00
			TOTAL CHARGES	119,148.00	0.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:55:04
Page: 6

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,584,812.49	ADJUSTMENTS	648,856.02
COVERED CHARGES	17,157,025.31	CONTRACTUAL ALLOW	13,517,083.86
NON-COVERD CHARGES	1,427,787.18	TOTAL MEDICAID LIAB	3,639,941.45
		LESS: COB	30,503.36
		LESS: COPAYMENT	9,825.89
		REIMBURSEMENT	3,599,612.20
		ALL OTHER	2,970,994.90
		FEE SCHEDULE-LAB	356,853.34
		INJECTABLE DRUGS	271,763.96

TOTAL NUMBER OF CLAIMS 8,903

CANDLER HOSPITAL
 5353 REYNOLDS ST
 SAVANNAH,GA 31405-6005

PROVIDER NUMBER
 000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	830,648.14	90,237.82	OTHER LAB	68,565.00	0.00
MED/SURG SUPPLY	576,824.64	1,513.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	4,106.00	0.00
RADIOLOGY-DIAGNOSTIC	1,037,628.00	26,956.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,433,917.00	126,117.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	39,759.00	12,063.02	FEE SCHEDULE LAB	2,428,123.65	257,440.20
EKG/ECG	71,459.00	1,452.00	MRI SERVICES	291,155.00	24,164.00
IV THERAPY	1,388,852.00	18,296.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,196,495.79	134,079.21	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	101,745.00	855.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	40,926.00	4,463.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	457,882.00	596.00	AMBULANCE	0.00	0.00
GI SERVICES	77,788.00	12,250.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,908,543.29	2,213.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	455,693.00	1,587.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	848,912.24	348,632.69
RADIOLOGY THERAPEUTIC	1,250,673.00	99,027.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	18,807.00	11,548.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,250.00	5,140.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,551.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,188.00	218.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	140,834.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	835,150.00	157,236.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	178,308.00	65,445.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	39,449.00	3,633.00			
AUDIOLOGY	5,186.00	0.00			
CARDIOLOGY	19,660.00	780.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	52,796.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	348,701.56	17,294.24			
			TOTAL ANCILLARY	17,157,025.31	1,427,787.18
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,157,025.31	1,427,787.18

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	325,756.17	ADJUSTMENTS	0.00
COVERED CHARGES	253,592.75	CONTRACTUAL ALLOW	193,868.70
NON-COVERD CHARGES	72,163.42	TOTAL MEDICAID LIAB	59,724.05
		LESS: COB	59,547.81
		LESS: COPAYMENT	176.24
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 129

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,049.17	490.86	OTHER LAB	410.00	0.00
MED/SURG SUPPLY	13,509.00	1,441.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,022.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,548.00	10,706.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	41,979.00	6,482.00
EKG/ECG	847.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	29,511.00	566.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,476.00	23,232.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,405.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,536.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,470.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	29,811.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,522.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,864.58	14,701.56
RADIOLOGY THERAPEUTIC	7,265.00	3,695.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	605.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	10,904.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,860.00	6,605.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,284.00	2,860.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,349.00	1,384.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,243.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,123.00	0.00			
			TOTAL ANCILLARY	253,592.75	72,163.42
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	253,592.75	72,163.42

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,018,736.82	ADJUSTMENTS	1,650.13
COVERED CHARGES	974,534.19	CONTRACTUAL ALLOW	923,013.49
NON-COVERD CHARGES	44,202.63	TOTAL MEDICAID LIAB	51,520.70
		LESS: COB	50.00
		LESS: COPAYMENT	1,776.05
		REIMBURSEMENT	49,694.65
		TOTAL NUMBER OF CLAIMS	921

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,826.99	275.91	OTHER LAB	14,178.00	0.00
MED/SURG SUPPLY	4,808.87	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	101,245.00	948.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	50,346.00	12,308.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,083.00	608.00	FEE SCHEDULE LAB	107,444.00	8,714.00
EKG/ECG	5,445.00	0.00	MRI SERVICES	8,913.00	4,212.00
IV THERAPY	96,209.00	530.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,836.00	7,680.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,327.00	266.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,192.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	518,521.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,468.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,654.33	205.72
RADIOLOGY THERAPEUTIC	1,797.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,770.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	32,442.00	8,455.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,028.00	0.00			
			TOTAL ANCILLARY	974,534.19	44,202.63
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	974,534.19	44,202.63

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	48,130.00	ADJUSTMENTS	0.00
COVERED CHARGES	42,854.00	CONTRACTUAL ALLOW	32,108.49
NON-COVERD CHARGES	5,276.00	TOTAL MEDICAID LIAB	10,745.51
		LESS: COB	10,718.51
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	31

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	114.00	297.00	OTHER LAB	410.00	0.00
MED/SURG SUPPLY	75.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,877.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,325.00	1,118.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,544.00	3,216.00
EKG/ECG	847.00	0.00	MRI SERVICES	2,018.00	0.00
IV THERAPY	3,195.00	84.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,427.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,050.00	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	1,972.00	461.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	42,854.00	5,276.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	42,854.00	5,276.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,844,106.07	ADJUSTMENTS	117,155.42
COVERED CHARGES	2,706,132.04	CONTRACTUAL ALLOW	2,257,422.63
NON-COVERD CHARGES	137,974.03	TOTAL MEDICAID LIAB	448,709.41
		LESS: COB	0.00
		LESS: COPAYMENT	1,000.05
		REIMBURSEMENT	447,709.36

TOTAL NUMBER OF CLAIMS 85

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	392,677.23	47,648.16	OTHER LAB	410.00	0.00
MED/SURG SUPPLY	98,731.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,077.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,365.00	3,918.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	41,886.20	466.80
EKG/ECG	605.00	121.00	MRI SERVICES	9,881.00	0.00
IV THERAPY	169,460.00	1,142.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	227,119.00	50,336.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	95,598.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,955.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	47,954.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	424,252.61	16,502.07
RADIOLOGY THERAPEUTIC	987,808.00	1,758.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	73,280.00	0.00
LITHOTRIPSY	71,259.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,172.00	461.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	21,136.00	10,550.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,681.00	4,138.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	780.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,045.00	933.00			
			TOTAL ANCILLARY	2,706,132.04	137,974.03
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,706,132.04	137,974.03

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	88,206.00	ADJUSTMENTS	0.00
COVERED CHARGES	78,980.00	CONTRACTUAL ALLOW	35,029.58
NON-COVERD CHARGES	9,226.00	TOTAL MEDICAID LIAB	43,950.42
		LESS: COB	43,911.42
		LESS: COPAYMENT	39.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

Report : CLM-0814-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	280.00	177.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	478.00	4,665.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	22.00	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	4,224.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,192.00	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	1,587.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	650.00	160.00
RADIOLOGY THERAPEUTIC	42,678.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	32,093.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	78,980.00	9,226.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	78,980.00	9,226.00

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 00:55:55
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

SOUTHERN REGIONAL MEDICAL CENTER
 11 UPPER RIVERDALE RD SW
 RIVERDALE,GA 30274-2615

PROVIDER NUMBER 000000404A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	46,145,865.07	ADJUSTMENTS	1,851,063.63
COVERED CHARGES	44,150,235.83	CONTRACTUAL ALLOW	31,663,742.29
NON-COVERD CHARGES	1,995,629.24	TOTAL MEDICAID LIAB	12,486,493.54
		LESS: COB	85,474.94
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	12,401,018.60

TOTAL NUMBER OF ADMISSIONS 2,248

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	6,444		0	5,923,081.08		521,192.92
ROUTINE NURSERY	1,784		12	2,638,631.00		18,594.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	8,228		12	8,561,712.08		539,786.92
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,203		0	3,136,384.00		0.00
NICU	314		0	979,048.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,517		0	4,115,432.00		0.00
TOTAL ACCOMODATIONS	9,745		12	12,677,144.08		539,786.92

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

SOUTHERN REGIONAL MEDICAL CENTER
 11 UPPER RIVERDALE RD SW
 RIVERDALE,GA 30274-2615

PROVIDER NUMBER
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,485,042.44	47,365.11	OTHER LAB	164,769.87	0.00
MED/SURG SUPPLY	1,838,930.81	7,692.19	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,550,835.11	69,778.54	EDUCATION & TRAINING	43,156.58	136.19
RADIOLOGY-DIAGNOSTIC	585,133.49	1,417.00	OTHER THERAPEUTIC SVC	519.96	175.28
CT SCAN	930,917.49	398,522.14	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	178,345.68	13,612.45	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	235,254.92	494.00	MRI SERVICES	590,810.88	3,945.00
IV THERAPY	191,538.81	2,160.43	PROFESSIONAL FEES	0.00	314.00
OPERATING ROOM	1,646,175.42	9,368.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,122,292.02	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,599,173.41	9,549.65	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	571,896.89	0.00	AMBULANCE	0.00	0.00
GI SERVICES	372,404.41	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,070,225.25	5,879.97	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	435,709.53	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	276,075.18	0.00	INJECTABLE DRUGS	38,228.27	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	62,246.14	8,301.80	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	104,654.08	6,713.40	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	258,954.76	29,383.20	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	77,591.30	1,536.03	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	477,470.74	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	433,209.36	7,471.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	573,841.14	17,546.24			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	297,619.27	85,313.81			
AUDIOLOGY	95,737.38	721,528.90			
CARDIOLOGY	1,744,451.64	5,387.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	16,581.58	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	403,297.94	2,250.49			
			TOTAL ANCILLARY	31,473,091.75	1,455,842.32
			TOTAL ACCOMODATIONS	12,677,144.08	539,786.92
			TOTAL CHARGES	44,150,235.83	1,995,629.24

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

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

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SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

SOUTHERN REGIONAL MEDICAL CENTER
 11 UPPER RIVERDALE RD SW
 RIVERDALE,GA 30274-2615

PROVIDER NUMBER
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	294,463.14	ADJUSTMENTS	0.00
COVERED CHARGES	288,546.59	CONTRACTUAL ALLOW	111,016.72
NON-COVERD CHARGES	5,916.55	TOTAL MEDICAID LIAB	177,529.87
		LESS: COB	177,529.87
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 8

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	12		0	11,328.00		1,076.00
ROUTINE NURSERY	61		0	152,575.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	73		0	163,903.00		1,076.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	4		0	13,088.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	4		0	13,088.00		0.00
TOTAL ACCOMODATIONS	77		0	176,991.00		1,076.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

SOUTHERN REGIONAL MEDICAL CENTER
 11 UPPER RIVERDALE RD SW
 RIVERDALE,GA 30274-2615

PROVIDER NUMBER
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,669.52	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	18,972.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	20,893.40	0.00	EDUCATION & TRAINING	362.85	0.00
RADIOLOGY-DIAGNOSTIC	3,331.80	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,799.70	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	560.58	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,132.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,311.10	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	21,836.05	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,738.99	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,294.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	246.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,319.10	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,887.50	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	3,040.85			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	111,555.59	4,840.55
			TOTAL ACCOMODATIONS	176,991.00	1,076.00
			TOTAL CHARGES	288,546.59	5,916.55

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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SOUTHERN REGIONAL MEDICAL CENTER
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,565,486.05	ADJUSTMENTS	768,933.98
COVERED CHARGES	21,979,433.12	CONTRACTUAL ALLOW	17,748,486.53
NON-COVERD CHARGES	3,586,052.93	TOTAL MEDICAID LIAB	4,230,946.59
		LESS: COB	4,823.60
		LESS: COPAYMENT	5,296.81
		REIMBURSEMENT	4,220,826.18
		ALL OTHER	3,759,122.72
		FEE SCHEDULE-LAB	416,905.72
		INJECTABLE DRUGS	44,797.74

TOTAL NUMBER OF CLAIMS 8,567

SOUTHERN REGIONAL MEDICAL CENTER
 11 UPPER RIVERDALE RD SW
 RIVERDALE,GA 30274-2615

PROVIDER NUMBER
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	318,944.93	58,481.34	OTHER LAB	257,197.96	0.00
MED/SURG SUPPLY	438,136.51	66,649.53	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	935.33	EDUCATION & TRAINING	177.00	1,101.79
RADIOLOGY-DIAGNOSTIC	827,676.31	11,507.80	OTHER THERAPEUTIC SVC	0.00	5,176.72
CT SCAN	1,444,163.81	402,855.81	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	37,450.72	24,872.75	FEE SCHEDULE LAB	4,523,115.41	1,055,800.16
EKG/ECG	266,135.14	21,727.20	MRI SERVICES	401,752.75	67,001.08
IV THERAPY	393,042.53	45,255.30	PROFESSIONAL FEES	0.00	505.05
OPERATING ROOM	1,314,655.67	249,223.78	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	203,872.92	2,542.56	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	95,616.64	27,518.63	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	738,705.32	20,797.80	AMBULANCE	0.00	0.00
GI SERVICES	569,832.95	131,309.45	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,275,167.87	127,729.08	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	533,725.02	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	311,834.91	346,693.05
RADIOLOGY THERAPEUTIC	1,346.85	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	10,065.30	3,406.76	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,424.80	2,005.02	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	35,599.20	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	353,865.75	3,959.40	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	23,801.54	139,037.24
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	40,457.23
OTHER IMAGING SERVICE	1,346,559.49	279,554.68			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	67,672.04	10,282.64			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	390,594.05	141,332.28			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	405,796.91	227,684.99			
AMBULATORY SURGERY	6,701.67	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,571.81	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	412,828.54	35,049.28			
			TOTAL ANCILLARY	21,979,433.12	3,586,052.93
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	21,979,433.12	3,586,052.93

Report : CLM-0804-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 00:56:05
 Page: 7

SOUTHERN REGIONAL MEDICAL CENTER
 11 UPPER RIVERDALE RD SW
 RIVERDALE,GA 30274-2615

PROVIDER NUMBER
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013224028948	08/06/13 - 08/06/13	08/19/13	0.00	5,695.96	0.00	0.00	0.00
614	2013231054755	08/13/13 - 08/13/13	08/26/13	0.00	5,695.96	0.00	0.00	0.00
614	5913330002083	09/18/13 - 09/18/13	12/02/13	0.00	5,696.00	0.00	0.00	0.00
614	5913330002084	09/27/13 - 09/27/13	12/02/13	0.00	5,696.00	0.00	0.00	0.00
614	5913330002086	09/13/13 - 09/13/13	12/02/13	0.00	5,696.00	0.00	0.00	0.00
614	2214143002165	05/16/14 - 05/16/14	05/26/14	0.00	5,980.80	0.00	0.00	0.00
-1	1114204001201	12/11/13 - 12/11/13	08/25/14	0.00	15.71	0.00	0.00	0.00
614	2014260003573	06/02/14 - 06/02/14	09/22/14	0.00	5,980.80	0.00	0.00	0.00
TOTAL				0.00	40,457.23	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:56:33
Page: 8

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHERN REGIONAL MEDICAL CENTER
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	126,935.61	ADJUSTMENTS	0.00
COVERED CHARGES	47,759.83	CONTRACTUAL ALLOW	25,010.63
NON-COVERD CHARGES	79,175.78	TOTAL MEDICAID LIAB	22,749.20
		LESS: COB	22,729.52
		LESS: COPAYMENT	19.68
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 32

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHERN REGIONAL MEDICAL CENTER
 11 UPPER RIVERDALE RD SW
 RIVERDALE,GA 30274-2615

PROVIDER NUMBER
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	886.24	699.65	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,962.58	22.44	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	118.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,321.65	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,310.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,317.63	2,897.92
EKG/ECG	494.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,005.79	398.07	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	11,698.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,149.25	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,530.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,726.45	1,080.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,718.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	575.99	177.95
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	42,750.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,280.25	4,596.75			
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	12,427.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	792.00	0.00			
			TOTAL ANCILLARY	47,759.83	79,175.78
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	47,759.83	79,175.78

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:56:36
Page: 10

SOUTHERN REGIONAL MEDICAL CENTER
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,415,037.73	ADJUSTMENTS	2,438.22
COVERED CHARGES	1,315,532.72	CONTRACTUAL ALLOW	1,253,830.93
NON-COVERD CHARGES	99,505.01	TOTAL MEDICAID LIAB	61,701.79
		LESS: COB	0.00
		LESS: COPAYMENT	1,884.08
		REIMBURSEMENT	59,817.71
		TOTAL NUMBER OF CLAIMS	1,103

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHERN REGIONAL MEDICAL CENTER
 11 UPPER RIVERDALE RD SW
 RIVERDALE,GA 30274-2615

PROVIDER NUMBER
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,619.38	3,145.16	OTHER LAB	11,360.35	0.00
MED/SURG SUPPLY	4,678.83	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	55,581.71	869.45	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	42,042.03	15,732.70	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	229,830.31	59,999.75
EKG/ECG	14,741.50	0.00	MRI SERVICES	20,066.30	0.00
IV THERAPY	14,603.32	1,768.21	PROFESSIONAL FEES	0.00	21.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,490.58	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,846.32	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	845,817.59	2,924.49	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	6,904.30	5,623.44
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	123.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	44,352.65	9,237.81			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,220.40	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	807.00	60.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	1,173.27	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,396.88	0.00			
			TOTAL ANCILLARY	1,315,532.72	99,505.01
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,315,532.72	99,505.01

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:56:40
Page: 12

SOUTHERN REGIONAL MEDICAL CENTER
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	968.10	ADJUSTMENTS	0.00
COVERED CHARGES	968.10	CONTRACTUAL ALLOW	320.56
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	647.54
		LESS: COB	647.54
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHERN REGIONAL MEDICAL CENTER
 11 UPPER RIVERDALE RD SW
 RIVERDALE,GA 30274-2615

PROVIDER NUMBER
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 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	259.35	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	708.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	968.10	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	968.10	0.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHERN REGIONAL MEDICAL CENTER
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	718,401.21	ADJUSTMENTS	43,160.80
COVERED CHARGES	667,668.96	CONTRACTUAL ALLOW	552,567.16
NON-COVERD CHARGES	50,732.25	TOTAL MEDICAID LIAB	115,101.80
		LESS: COB	0.00
		LESS: COPAYMENT	81.00
		REIMBURSEMENT	115,020.80

TOTAL NUMBER OF CLAIMS 22

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHERN REGIONAL MEDICAL CENTER
 11 UPPER RIVERDALE RD SW
 RIVERDALE,GA 30274-2615

PROVIDER NUMBER
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,001.26	1,597.70	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	29,116.02	217.26	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,853.28	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,115.00	1,714.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	37,331.11	2,603.30
EKG/ECG	1,234.12	739.68	MRI SERVICES	5,382.00	0.00
IV THERAPY	8,465.58	351.27	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	258,721.16	4,710.66	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,389.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	46,360.35	1,733.15	AMBULANCE	0.00	0.00
GI SERVICES	6,728.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,319.01	420.90	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	32,860.88	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	119,411.52	11,092.50
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	53,219.97	256.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,430.53	861.55			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,368.29	424.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,720.00	1,802.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	18,634.96	21,816.69			
AMBULATORY SURGERY	0.00	391.09			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,006.92	0.00			
			TOTAL ANCILLARY	667,668.96	50,732.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	667,668.96	50,732.25

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHERN REGIONAL MEDICAL CENTER
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 00:56:53
 Page: 1

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	208,764.66	ADJUSTMENTS	0.00
COVERED CHARGES	208,377.66	CONTRACTUAL ALLOW	82,659.46
NON-COVERD CHARGES	387.00	TOTAL MEDICAID LIAB	125,718.20
		LESS: COB	4,341.54
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	121,376.66

TOTAL NUMBER OF ADMISSIONS 25

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	55		0	16,060.00		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	55		0	16,060.00		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	55		0	16,060.00		0.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	68,130.20	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	26,498.87	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	40,841.99	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,819.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,562.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	286.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	12,324.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	20,313.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,179.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,039.10	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,008.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	736.00	387.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	580.00	0.00			
			TOTAL ANCILLARY	192,317.66	387.00
			TOTAL ACCOMODATIONS	16,060.00	0.00
			TOTAL CHARGES	208,377.66	387.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

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CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	668,449.53	ADJUSTMENTS	12,985.47
COVERED CHARGES	569,734.59	CONTRACTUAL ALLOW	291,538.73
NON-COVERD CHARGES	98,714.94	TOTAL MEDICAID LIAB	278,195.86
		LESS: COB	0.00
		LESS: COPAYMENT	1,599.00
		REIMBURSEMENT	276,596.86
		ALL OTHER	250,285.07
		FEE SCHEDULE-LAB	26,311.79
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 874

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55,986.22	0.00	OTHER LAB	3,201.00	0.00
MED/SURG SUPPLY	26,991.67	721.74	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	36,473.00	39.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	70,475.00	9,343.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,073.00	3,265.00	FEE SCHEDULE LAB	215,820.70	62,151.70
EKG/ECG	17,724.00	5,745.00	MRI SERVICES	3,206.00	1,350.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	2,138.00
OPERATING ROOM	12,341.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,609.00	1,182.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	78,167.00	7,996.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,680.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	651.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	402.00
OTHER IMAGING SERVICE	12,779.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,249.00	2,166.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	15,890.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,418.00	2,215.00			
			TOTAL ANCILLARY	569,734.59	98,714.94
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	569,734.59	98,714.94

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2214199011205	06/09/14 - 06/09/14	07/21/14	0.00	402.00	0.00	0.00	0.00
TOTAL				0.00	402.00	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	79,858.83	ADJUSTMENTS	141.00
COVERED CHARGES	72,536.52	CONTRACTUAL ALLOW	61,291.52
NON-COVERD CHARGES	7,322.31	TOTAL MEDICAID LIAB	11,245.00
		LESS: COB	0.00
		LESS: COPAYMENT	420.00
		REIMBURSEMENT	10,825.00
		TOTAL NUMBER OF CLAIMS	225

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,777.35	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,690.11	99.31	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,805.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,866.00	2,694.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	207.00	218.00	FEE SCHEDULE LAB	15,377.06	2,747.00
EKG/ECG	324.00	232.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	817.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	415.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	30,712.00	515.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	118.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	245.00	0.00			
			TOTAL ANCILLARY	72,536.52	7,322.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	72,536.52	7,322.31

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:56:58
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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	73,678,800.99	ADJUSTMENTS	5,177,590.43
COVERED CHARGES	68,204,663.46	CONTRACTUAL ALLOW	50,399,412.80
NON-COVERD CHARGES	5,474,137.53	TOTAL MEDICAID LIAB	17,805,250.66
		LESS: COB	71,006.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	17,734,244.16

TOTAL NUMBER OF ADMISSIONS 2,219

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	6,089		309	6,116,982.00		3,478,196.75
ROUTINE NURSERY	985		23	811,846.70		97,771.80
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		122,579.00
TOTAL ROUTINE	7,074		332	6,928,828.70		3,698,547.55
SPECIAL CARE SERVICES						
CCU	2,850		22	4,698,156.93		69,166.00
ICU	803		6	2,054,690.34		73,740.00
NICU	922		0	2,460,546.50		13,302.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		99	0.00		146,322.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	4,575		127	9,213,393.77		302,530.00
TOTAL ACCOMODATIONS	11,649		459	16,142,222.47		4,001,077.55

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,265,342.14	277,230.90	OTHER LAB	525,729.75	2,276.00
MED/SURG SUPPLY	2,108,277.17	60,606.33	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,326,384.23	77,699.00	EDUCATION & TRAINING	26,484.00	659.00
RADIOLOGY-DIAGNOSTIC	1,284,573.73	10,546.00	OTHER THERAPEUTIC SVC	0.00	6,568.00
CT SCAN	2,774,148.00	11,796.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	340,845.00	16,657.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	515,640.00	2,716.00	MRI SERVICES	1,088,645.00	20,007.00
IV THERAPY	747,963.00	116,844.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,063,673.71	67,575.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,714,095.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,592,853.03	63,771.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,140,992.90	34,067.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,515,284.00	6,630.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,006,177.30	21,410.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	242,393.40	5,404.00	INJECTABLE DRUGS	936.00	0.00
RADIOLOGY THERAPEUTIC	5,844.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	192,170.00	16,103.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	111,331.00	7,243.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,869,080.00	84,075.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	47,211.34	5,306.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	176,242.60	3,702.00	IMPL DEV CHARGE PATIENTS	1,308,232.28	12,838.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	317,375.00
OTHER IMAGING SERVICE	495,624.07	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	509,125.79	168,066.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	517,847.00	34,887.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,221,563.00	13,538.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	136,044.00	3,336.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	191,688.55	4,128.00			
			TOTAL ANCILLARY	52,062,440.99	1,473,059.98
			TOTAL ACCOMODATIONS	16,142,222.47	4,001,077.55
			TOTAL CHARGES	68,204,663.46	5,474,137.53

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013196021813	07/09/13 - 07/10/13	07/22/13	0.00	275.00	0.00	0.00	0.00
905	2013196021827	07/01/13 - 07/08/13	07/22/13	0.00	275.00	0.00	0.00	0.00
905	2013196022180	07/04/13 - 07/08/13	07/22/13	0.00	1,100.00	0.00	0.00	0.00
905	2013196022196	07/04/13 - 07/08/13	07/22/13	0.00	275.00	0.00	0.00	0.00
905	2013197044592	07/02/13 - 07/08/13	07/22/13	0.00	1,375.00	0.00	0.00	0.00
905	2013203027379	07/12/13 - 07/16/13	07/29/13	0.00	550.00	0.00	0.00	0.00
905	2013203027412	07/09/13 - 07/16/13	07/29/13	0.00	825.00	0.00	0.00	0.00
905	2013203027423	07/11/13 - 07/16/13	07/29/13	0.00	275.00	0.00	0.00	0.00
905	2013203027480	07/11/13 - 07/16/13	07/29/13	0.00	275.00	0.00	0.00	0.00
905	2013203027567	07/03/13 - 07/13/13	07/29/13	0.00	2,475.00	0.00	0.00	0.00
905	2013203027580	07/11/13 - 07/15/13	07/29/13	0.00	1,100.00	0.00	0.00	0.00
905	2013204046387	07/12/13 - 07/17/13	07/29/13	0.00	1,100.00	0.00	0.00	0.00
905	2013205068578	07/10/13 - 07/12/13	07/29/13	0.00	275.00	0.00	0.00	0.00
905	2013205068611	07/12/13 - 07/18/13	07/29/13	0.00	550.00	0.00	0.00	0.00
905	2013205068740	07/09/13 - 07/17/13	07/29/13	0.00	1,100.00	0.00	0.00	0.00
905	2013210030128	07/16/13 - 07/23/13	08/05/13	0.00	1,375.00	0.00	0.00	0.00
905	2013210030130	07/15/13 - 07/22/13	08/05/13	0.00	1,650.00	0.00	0.00	0.00
905	2013210030139	07/11/13 - 07/22/13	08/05/13	0.00	1,650.00	0.00	0.00	0.00
905	2013211044547	07/22/13 - 07/25/13	08/05/13	0.00	550.00	0.00	0.00	0.00
905	2013211044552	07/17/13 - 07/22/13	08/05/13	0.00	1,375.00	0.00	0.00	0.00
905	2013212065177	07/17/13 - 07/22/13	08/05/13	0.00	275.00	0.00	0.00	0.00
905	2013212065249	07/18/13 - 07/23/13	08/05/13	0.00	1,100.00	0.00	0.00	0.00
905	2013213083975	07/17/13 - 07/23/13	08/05/13	0.00	2,200.00	0.00	0.00	0.00
905	2013213084127	07/19/13 - 07/22/13	08/05/13	0.00	825.00	0.00	0.00	0.00
905	2013217034271	07/09/13 - 07/15/13	08/12/13	0.00	2,200.00	0.00	0.00	0.00
905	2013219072804	07/12/13 - 07/19/13	08/12/13	0.00	275.00	0.00	0.00	0.00
905	2013226063682	08/01/13 - 08/05/13	08/19/13	0.00	1,650.00	0.00	0.00	0.00
905	2013226063697	08/01/13 - 08/06/13	08/19/13	0.00	2,200.00	0.00	0.00	0.00
905	2013226063712	07/26/13 - 07/30/13	08/19/13	0.00	825.00	0.00	0.00	0.00
905	2013226063724	07/23/13 - 07/30/13	08/19/13	0.00	1,375.00	0.00	0.00	0.00
905	2013226063863	08/03/13 - 08/09/13	08/19/13	0.00	1,100.00	0.00	0.00	0.00
905	2013226063934	07/24/13 - 07/28/13	08/19/13	0.00	1,375.00	0.00	0.00	0.00
905	2013226063938	08/03/13 - 08/09/13	08/19/13	0.00	275.00	0.00	0.00	0.00
905	2013226063943	07/25/13 - 07/30/13	08/19/13	0.00	1,375.00	0.00	0.00	0.00
905	2013227060949	07/24/13 - 07/26/13	08/19/13	0.00	275.00	0.00	0.00	0.00
905	2013228075808	08/03/13 - 08/09/13	08/26/13	0.00	2,200.00	0.00	0.00	0.00
905	2013231054822	08/07/13 - 08/12/13	08/26/13	0.00	275.00	0.00	0.00	0.00
905	2013231054890	07/18/13 - 08/01/13	08/26/13	0.00	3,300.00	0.00	0.00	0.00
905	2013231054916	08/07/13 - 08/13/13	08/26/13	0.00	1,100.00	0.00	0.00	0.00
905	2013232041517	08/09/13 - 08/14/13	08/26/13	0.00	550.00	0.00	0.00	0.00
905	2013232041766	08/08/13 - 08/14/13	08/26/13	0.00	1,375.00	0.00	0.00	0.00
905	2013233089096	07/24/13 - 07/30/13	08/26/13	0.00	1,375.00	0.00	0.00	0.00

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3950 AUSTELL RD
AUSTELL,GA 30106-1121

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SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CLM#	PROVIDER#	START DATE	END DATE	PROVIDER#	AMOUNT	PAYMENT DATES	THROUGH	ADMISSION DATES	THROUGH
905	2013233089130	08/08/13	08/12/13	08/26/13	0.00	0.00	0.00	0.00	0.00
905	2013233089146	08/12/13	08/16/13	08/26/13	0.00	0.00	0.00	0.00	0.00
905	2013234055248	07/10/13	08/01/13	08/26/13	0.00	1,100.00	0.00	0.00	0.00
905	2013235104915	08/11/13	08/18/13	09/02/13	0.00	1,375.00	0.00	0.00	0.00
905	2013235105040	08/06/13	08/11/13	09/02/13	0.00	1,650.00	0.00	0.00	0.00
905	2013235105045	07/31/13	08/03/13	09/02/13	0.00	275.00	0.00	0.00	0.00
905	2013235105068	08/09/13	08/14/13	09/02/13	0.00	550.00	0.00	0.00	0.00
905	2013238033004	08/13/13	08/19/13	09/02/13	0.00	275.00	0.00	0.00	0.00
905	2013238033030	07/18/13	07/24/13	09/02/13	0.00	275.00	0.00	0.00	0.00
905	2013238033036	08/10/13	08/16/13	09/02/13	0.00	550.00	0.00	0.00	0.00
905	2013239052318	08/20/13	08/21/13	09/02/13	0.00	275.00	0.00	0.00	0.00
905	2013239052418	07/27/13	07/30/13	09/02/13	0.00	825.00	0.00	0.00	0.00
905	2013239052640	08/11/13	08/14/13	09/02/13	0.00	550.00	0.00	0.00	0.00
905	2213242014487	08/06/13	08/13/13	09/02/13	0.00	550.00	0.00	0.00	0.00
905	2013247077555	08/19/13	08/24/13	09/09/13	0.00	550.00	0.00	0.00	0.00
905	2013247077617	08/19/13	08/27/13	09/09/13	0.00	825.00	0.00	0.00	0.00
905	2013247077679	08/19/13	08/26/13	09/09/13	0.00	1,925.00	0.00	0.00	0.00
905	2013247077740	08/22/13	08/29/13	09/09/13	0.00	825.00	0.00	0.00	0.00
905	2013247077761	08/20/13	08/26/13	09/09/13	0.00	825.00	0.00	0.00	0.00
905	2013248086241	08/04/13	08/08/13	09/09/13	0.00	550.00	0.00	0.00	0.00
905	2013248086396	08/21/13	08/26/13	09/09/13	0.00	1,375.00	0.00	0.00	0.00
615	2013248086404	08/08/13	08/12/13	09/09/13	0.00	3,498.00	0.00	0.00	0.00
905	2013248086623	08/22/13	08/27/13	09/09/13	0.00	1,375.00	0.00	0.00	0.00
905	2013248086662	08/09/13	08/14/13	09/09/13	0.00	275.00	0.00	0.00	0.00
905	2013248086712	08/15/13	08/20/13	09/09/13	0.00	1,100.00	0.00	0.00	0.00
905	2013252031452	08/24/13	08/31/13	09/16/13	0.00	275.00	0.00	0.00	0.00
905	2013252031672	08/23/13	08/27/13	09/16/13	0.00	275.00	0.00	0.00	0.00
615	2013252031698	08/29/13	09/02/13	09/16/13	0.00	3,498.00	0.00	0.00	0.00
905	2013252031898	08/21/13	08/26/13	09/16/13	0.00	1,100.00	0.00	0.00	0.00
905	2013253058397	08/30/13	09/05/13	09/16/13	0.00	275.00	0.00	0.00	0.00
905	2013253058429	08/23/13	08/27/13	09/16/13	0.00	550.00	0.00	0.00	0.00
905	2013253058441	08/21/13	09/02/13	09/16/13	0.00	275.00	0.00	0.00	0.00
905	2013254070133	09/01/13	09/06/13	09/16/13	0.00	275.00	0.00	0.00	0.00
905	2013254070139	09/01/13	09/05/13	09/16/13	0.00	550.00	0.00	0.00	0.00
905	2013254070151	09/02/13	09/06/13	09/16/13	0.00	825.00	0.00	0.00	0.00
905	2013254070196	08/25/13	08/29/13	09/16/13	0.00	825.00	0.00	0.00	0.00
905	2013255070184	08/29/13	09/02/13	09/16/13	0.00	1,100.00	0.00	0.00	0.00
905	2013255070309	08/31/13	09/06/13	09/16/13	0.00	550.00	0.00	0.00	0.00
905	2013259053090	08/22/13	09/02/13	09/23/13	0.00	275.00	0.00	0.00	0.00
905	2013259053392	09/07/13	09/10/13	09/23/13	0.00	825.00	0.00	0.00	0.00
905	2013259053426	09/06/13	09/11/13	09/23/13	0.00	550.00	0.00	0.00	0.00
905	2013259053444	09/02/13	09/09/13	09/23/13	0.00	550.00	0.00	0.00	0.00
905	2013260040563	09/08/13	09/12/13	09/23/13	0.00	550.00	0.00	0.00	0.00
905	2013261075441	09/07/13	09/11/13	09/23/13	0.00	1,375.00	0.00	0.00	0.00
905	2013262056370	09/07/13	09/13/13	09/23/13	0.00	1,375.00	0.00	0.00	0.00
905	2013262056428	09/10/13	09/14/13	09/23/13	0.00	275.00	0.00	0.00	0.00

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ADMISSION DATES 00/00/00 THROUGH 00/00/00

CLM	CLM	CLM	CLM	CLM	CLM	CLM	CLM	CLM	CLM
905	2013262056506	09/06/13 - 09/13/13	09/23/13	0.00	1,650.00	0.00	0.00	0.00	0.00
905	2013262056523	09/10/13 - 09/12/13	09/23/13	0.00	275.00	0.00	0.00	0.00	0.00
905	2013262056657	09/11/13 - 09/13/13	09/23/13	0.00	275.00	0.00	0.00	0.00	0.00
905	2013262056799	08/14/13 - 08/19/13	09/23/13	0.00	2,200.00	0.00	0.00	0.00	0.00
905	2013262056816	09/10/13 - 09/14/13	09/23/13	0.00	825.00	0.00	0.00	0.00	0.00
905	2013266064197	09/10/13 - 09/18/13	09/30/13	0.00	1,925.00	0.00	0.00	0.00	0.00
905	2013267066434	09/05/13 - 09/16/13	09/30/13	0.00	1,375.00	0.00	0.00	0.00	0.00
905	2013267066599	09/14/13 - 09/17/13	09/30/13	0.00	275.00	0.00	0.00	0.00	0.00
905	2013267066706	09/10/13 - 09/17/13	09/30/13	0.00	1,925.00	0.00	0.00	0.00	0.00
905	2013268064521	09/13/13 - 09/18/13	09/30/13	0.00	550.00	0.00	0.00	0.00	0.00
905	2013268064763	09/16/13 - 09/20/13	09/30/13	0.00	275.00	0.00	0.00	0.00	0.00
905	2013273033523	09/17/13 - 09/23/13	10/07/13	0.00	275.00	0.00	0.00	0.00	0.00
905	2013273033579	09/16/13 - 09/23/13	10/07/13	0.00	275.00	0.00	0.00	0.00	0.00
905	2013273033671	09/18/13 - 09/23/13	10/07/13	0.00	825.00	0.00	0.00	0.00	0.00
905	2013273033765	09/18/13 - 09/23/13	10/07/13	0.00	275.00	0.00	0.00	0.00	0.00
905	2013274063885	09/23/13 - 09/26/13	10/07/13	0.00	825.00	0.00	0.00	0.00	0.00
905	2013274063943	09/17/13 - 09/23/13	10/07/13	0.00	1,100.00	0.00	0.00	0.00	0.00
905	2013274063951	09/13/13 - 09/25/13	10/07/13	0.00	825.00	0.00	0.00	0.00	0.00
905	2013274064016	09/19/13 - 09/25/13	10/07/13	0.00	825.00	0.00	0.00	0.00	0.00
905	2013275079225	09/20/13 - 09/24/13	10/07/13	0.00	825.00	0.00	0.00	0.00	0.00
905	2013275079229	09/26/13 - 09/27/13	10/07/13	0.00	550.00	0.00	0.00	0.00	0.00
905	2013276080066	09/23/13 - 09/27/13	10/07/13	0.00	1,650.00	0.00	0.00	0.00	0.00
905	2013276080358	09/17/13 - 09/23/13	10/07/13	0.00	2,198.00	0.00	0.00	0.00	0.00
905	2013280034783	09/26/13 - 10/01/13	10/14/13	0.00	825.00	0.00	0.00	0.00	0.00
905	2013280034858	09/23/13 - 09/30/13	10/14/13	0.00	825.00	0.00	0.00	0.00	0.00
905	2013280034911	09/28/13 - 10/02/13	10/14/13	0.00	275.00	0.00	0.00	0.00	0.00
905	2013280034949	09/26/13 - 10/02/13	10/14/13	0.00	1,375.00	0.00	0.00	0.00	0.00
905	2013281060132	09/27/13 - 10/03/13	10/14/13	0.00	550.00	0.00	0.00	0.00	0.00
905	2013281060162	09/27/13 - 10/03/13	10/14/13	0.00	275.00	0.00	0.00	0.00	0.00
905	2013283010988	09/27/13 - 10/02/13	10/14/13	0.00	1,100.00	0.00	0.00	0.00	0.00
905	2013283097138	09/24/13 - 09/30/13	10/14/13	0.00	825.00	0.00	0.00	0.00	0.00
905	2013283097325	09/25/13 - 10/04/13	10/14/13	0.00	550.00	0.00	0.00	0.00	0.00
905	2013283097356	09/24/13 - 09/27/13	10/14/13	0.00	275.00	0.00	0.00	0.00	0.00
905	2013283097670	10/03/13 - 10/04/13	10/14/13	0.00	275.00	0.00	0.00	0.00	0.00
905	2013283097700	09/26/13 - 09/26/13	10/14/13	0.00	275.00	0.00	0.00	0.00	0.00
905	2013283097768	09/30/13 - 10/04/13	10/14/13	0.00	275.00	0.00	0.00	0.00	0.00
905	2013287030793	10/02/13 - 10/07/13	10/21/13	0.00	275.00	0.00	0.00	0.00	0.00
905	2013287030921	10/04/13 - 10/08/13	10/21/13	0.00	825.00	0.00	0.00	0.00	0.00
905	2013288068397	10/04/13 - 10/09/13	10/21/13	0.00	550.00	0.00	0.00	0.00	0.00
905	2013288068413	10/08/13 - 10/10/13	10/21/13	0.00	275.00	0.00	0.00	0.00	0.00
905	2013289048353	10/05/13 - 10/11/13	10/21/13	0.00	1,100.00	0.00	0.00	0.00	0.00
905	2013295047758	10/09/13 - 10/15/13	10/28/13	0.00	275.00	0.00	0.00	0.00	0.00
905	2013296084337	10/12/13 - 10/16/13	10/28/13	0.00	825.00	0.00	0.00	0.00	0.00
905	2013296084344	10/12/13 - 10/17/13	10/28/13	0.00	550.00	0.00	0.00	0.00	0.00
905	2013296084526	10/11/13 - 10/18/13	10/28/13	0.00	1,100.00	0.00	0.00	0.00	0.00
905	2013296084595	10/09/13 - 10/17/13	10/28/13	0.00	275.00	0.00	0.00	0.00	0.00

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SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CLM	CLM	CLM	CLM	CLM	CLM	CLM	CLM	CLM
905	2013297081888	10/14/13 - 10/16/13	10/28/13	0.00	275.00	0.00	0.00	0.00
905	2013297081901	10/08/13 - 10/19/13	10/28/13	0.00	825.00	0.00	0.00	0.00
905	2013298048872	10/14/13 - 10/18/13	11/04/13	0.00	275.00	0.00	0.00	0.00
905	2013301040354	09/22/13 - 09/30/13	11/04/13	0.00	1,650.00	0.00	0.00	0.00
905	2013301040457	10/17/13 - 10/22/13	11/04/13	0.00	275.00	0.00	0.00	0.00
905	2013301040489	10/19/13 - 10/23/13	11/04/13	0.00	275.00	0.00	0.00	0.00
905	2013302052109	10/17/13 - 10/22/13	11/04/13	0.00	275.00	0.00	0.00	0.00
905	2013308039760	10/26/13 - 10/28/13	11/11/13	0.00	275.00	0.00	0.00	0.00
905	2013308039782	10/21/13 - 10/28/13	11/11/13	0.00	275.00	0.00	0.00	0.00
905	2013309064598	10/25/13 - 10/31/13	11/11/13	0.00	825.00	0.00	0.00	0.00
905	2013309064651	10/23/13 - 10/31/13	11/11/13	0.00	825.00	0.00	0.00	0.00
905	2013309065146	10/21/13 - 10/31/13	11/11/13	0.00	275.00	0.00	0.00	0.00
905	2013312078138	10/24/13 - 10/28/13	11/18/13	0.00	550.00	0.00	0.00	0.00
905	2013312078150	10/12/13 - 10/18/13	11/18/13	0.00	550.00	0.00	0.00	0.00
905	2013315034689	10/26/13 - 11/04/13	11/18/13	0.00	275.00	0.00	0.00	0.00
905	2013315034758	11/01/13 - 11/04/13	11/18/13	0.00	825.00	0.00	0.00	0.00
905	2013316039920	10/28/13 - 11/05/13	11/18/13	0.00	1,100.00	0.00	0.00	0.00
905	2013316073141	10/31/13 - 11/05/13	11/18/13	0.00	825.00	0.00	0.00	0.00
905	2013316073413	11/01/13 - 11/07/13	11/18/13	0.00	550.00	0.00	0.00	0.00
905	2013316073440	11/01/13 - 11/05/13	12/16/13	0.00	550.00	0.00	0.00	0.00
905	2013316073487	10/02/13 - 10/11/13	11/18/13	0.00	1,100.00	0.00	0.00	0.00
905	2013316073580	10/19/13 - 10/25/13	11/18/13	0.00	550.00	0.00	0.00	0.00
905	2013318040333	11/04/13 - 11/08/13	11/18/13	0.00	275.00	0.00	0.00	0.00
905	2013319062757	11/05/13 - 11/08/13	11/25/13	0.00	550.00	0.00	0.00	0.00
905	2013322043676	10/07/13 - 10/14/13	11/25/13	0.00	550.00	0.00	0.00	0.00
905	2013322043793	11/07/13 - 11/12/13	11/25/13	0.00	1,650.00	0.00	0.00	0.00
905	2013322043802	11/06/13 - 11/12/13	11/25/13	0.00	825.00	0.00	0.00	0.00
905	2013322043833	11/06/13 - 11/11/13	11/25/13	0.00	1,925.00	0.00	0.00	0.00
905	2013323056930	11/05/13 - 11/11/13	11/25/13	0.00	275.00	0.00	0.00	0.00
905	2013323056936	11/07/13 - 11/13/13	11/25/13	0.00	275.00	0.00	0.00	0.00
905	2013323056961	11/05/13 - 11/08/13	11/25/13	0.00	275.00	0.00	0.00	0.00
905	2013323057013	11/04/13 - 11/11/13	11/25/13	0.00	825.00	0.00	0.00	0.00
905	2013324068952	11/09/13 - 11/15/13	11/25/13	0.00	825.00	0.00	0.00	0.00
905	2013324068968	11/09/13 - 11/15/13	11/25/13	0.00	275.00	0.00	0.00	0.00
905	2013329033193	10/26/13 - 10/31/13	12/02/13	0.00	550.00	0.00	0.00	0.00
905	2013330051587	11/15/13 - 11/21/13	12/02/13	0.00	1,100.00	0.00	0.00	0.00
905	2013330052171	11/15/13 - 11/19/13	12/02/13	0.00	825.00	0.00	0.00	0.00
905	2013331099288	11/19/13 - 11/22/13	12/02/13	0.00	550.00	0.00	0.00	0.00
905	2013333048172	11/18/13 - 11/22/13	12/09/13	0.00	1,100.00	0.00	0.00	0.00
905	2013336036760	11/19/13 - 11/22/13	12/09/13	0.00	1,375.00	0.00	0.00	0.00
905	2013339013766	11/09/13 - 11/20/13	12/09/13	0.00	1,650.00	0.00	0.00	0.00
905	2013340133331	11/19/13 - 11/26/13	12/16/13	0.00	275.00	0.00	0.00	0.00
905	2013340133338	11/24/13 - 11/27/13	12/16/13	0.00	550.00	0.00	0.00	0.00
905	2013340133356	11/19/13 - 11/26/13	12/16/13	0.00	825.00	0.00	0.00	0.00
905	2013343035585	11/18/13 - 11/26/13	12/16/13	0.00	275.00	0.00	0.00	0.00
905	2013343035590	11/24/13 - 11/27/13	12/16/13	0.00	275.00	0.00	0.00	0.00

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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CLM#	CLM#	INPATIENT DATES	PROVIDER DATE	CHARGE	PAID AMT	ADMITTED	DISCHG	CHARGE	PAID AMT
905	2013343035788	11/16/13 - 11/22/13	12/16/13	0.00	1,100.00	0.00	0.00	0.00	0.00
905	2013344060953	11/16/13 - 12/03/13	12/16/13	0.00	1,375.00	0.00	0.00	0.00	0.00
905	2013346078086	11/30/13 - 12/06/13	12/16/13	0.00	275.00	0.00	0.00	0.00	0.00
905	2213352001953	08/08/13 - 08/20/13	12/23/13	0.00	2,200.00	0.00	0.00	0.00	0.00
905	2013352071220	12/10/13 - 12/13/13	12/23/13	0.00	825.00	0.00	0.00	0.00	0.00
905	2213357002773	08/08/13 - 08/09/13	12/30/13	0.00	275.00	0.00	0.00	0.00	0.00
905	2013357038418	12/10/13 - 12/18/13	12/30/13	0.00	2,200.00	0.00	0.00	0.00	0.00
905	2013357038474	12/11/13 - 12/16/13	12/30/13	0.00	1,100.00	0.00	0.00	0.00	0.00
615	2013358043378	12/11/13 - 12/14/13	12/30/13	0.00	4,257.00	0.00	0.00	0.00	0.00
905	2013358043534	12/13/13 - 12/16/13	12/30/13	0.00	275.00	0.00	0.00	0.00	0.00
905	2013358043677	12/11/13 - 12/18/13	12/30/13	0.00	550.00	0.00	0.00	0.00	0.00
905	2013358043690	12/13/13 - 12/18/13	12/30/13	0.00	1,375.00	0.00	0.00	0.00	0.00
905	2013359030773	12/13/13 - 12/17/13	12/30/13	0.00	550.00	0.00	0.00	0.00	0.00
905	2013360096439	11/25/13 - 11/29/13	12/30/13	0.00	550.00	0.00	0.00	0.00	0.00
905	2013361042620	11/25/13 - 12/10/13	01/06/14	0.00	550.00	0.00	0.00	0.00	0.00
615	2013364030867	12/20/13 - 12/23/13	01/06/14	0.00	7,755.00	0.00	0.00	0.00	0.00
905	2013364030933	12/16/13 - 12/20/13	01/06/14	0.00	550.00	0.00	0.00	0.00	0.00
905	2013364030966	12/10/13 - 12/19/13	01/06/14	0.00	825.00	0.00	0.00	0.00	0.00
905	2013365054846	12/13/13 - 12/19/13	01/06/14	0.00	550.00	0.00	0.00	0.00	0.00
905	2014003056573	12/26/13 - 12/27/13	01/13/14	0.00	275.00	0.00	0.00	0.00	0.00
905	2014003056825	12/22/13 - 12/23/13	01/13/14	0.00	275.00	0.00	0.00	0.00	0.00
905	2014006038613	12/24/13 - 12/29/13	01/13/14	0.00	550.00	0.00	0.00	0.00	0.00
905	2014006038820	12/24/13 - 12/30/13	01/13/14	0.00	275.00	0.00	0.00	0.00	0.00
905	2014008061215	12/18/13 - 12/20/13	01/13/14	0.00	275.00	0.00	0.00	0.00	0.00
905	2014009066172	12/31/13 - 01/04/14	01/13/14	0.00	550.00	0.00	0.00	0.00	0.00
905	2014013037005	12/13/13 - 01/07/14	01/20/14	0.00	2,475.00	0.00	0.00	0.00	0.00
905	2014013037101	01/04/14 - 01/08/14	01/20/14	0.00	275.00	0.00	0.00	0.00	0.00
905	2014015004630	12/31/13 - 01/07/14	01/20/14	0.00	1,375.00	0.00	0.00	0.00	0.00
905	2014017004520	01/04/14 - 01/10/14	01/20/14	0.00	275.00	0.00	0.00	0.00	0.00
905	2014018000857	12/31/13 - 01/06/14	01/27/14	0.00	275.00	0.00	0.00	0.00	0.00
905	2014021023896	01/03/14 - 01/13/14	01/27/14	0.00	550.00	0.00	0.00	0.00	0.00
905	2014022099078	01/06/14 - 01/13/14	01/27/14	0.00	550.00	0.00	0.00	0.00	0.00
905	2014022099400	01/02/14 - 01/17/14	01/27/14	0.00	3,575.00	0.00	0.00	0.00	0.00
905	2014022099407	01/03/14 - 01/13/14	01/27/14	0.00	275.00	0.00	0.00	0.00	0.00
905	2014022099429	01/06/14 - 01/10/14	01/27/14	0.00	275.00	0.00	0.00	0.00	0.00
905	2014022099519	01/08/14 - 01/13/14	01/27/14	0.00	275.00	0.00	0.00	0.00	0.00
905	2014023073088	01/14/14 - 01/18/14	01/27/14	0.00	1,375.00	0.00	0.00	0.00	0.00
905	2014024082331	01/13/14 - 01/17/14	02/03/14	0.00	1,925.00	0.00	0.00	0.00	0.00
905	2014029047840	01/14/14 - 01/20/14	02/03/14	0.00	550.00	0.00	0.00	0.00	0.00
905	2014029048186	01/14/14 - 01/21/14	02/03/14	0.00	825.00	0.00	0.00	0.00	0.00
905	2014029048854	01/21/14 - 01/23/14	02/03/14	0.00	275.00	0.00	0.00	0.00	0.00
905	2014029048927	01/16/14 - 01/21/14	02/03/14	0.00	825.00	0.00	0.00	0.00	0.00
905	2014029049072	01/18/14 - 01/22/14	02/03/14	0.00	825.00	0.00	0.00	0.00	0.00
905	2014036052169	01/25/14 - 01/30/14	02/10/14	0.00	825.00	0.00	0.00	0.00	0.00
905	2014036052194	01/19/14 - 01/27/14	02/10/14	0.00	2,200.00	0.00	0.00	0.00	0.00
905	2014036052690	01/21/14 - 01/27/14	02/10/14	0.00	1,650.00	0.00	0.00	0.00	0.00

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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CLM#	ICD9	DATE	DATE	DATE	AMOUNT	PAYMENT	THROUGH	THROUGH
905	2014036053278	01/22/14	- 01/30/14	02/10/14	0.00	1,100.00	0.00	0.00
905	2014036091666	01/22/14	- 01/24/14	02/10/14	0.00	275.00	0.00	0.00
905	2014037081998	01/24/14	- 01/30/14	02/10/14	0.00	550.00	0.00	0.00
905	2014037082860	01/12/14	- 01/16/14	02/10/14	0.00	550.00	0.00	0.00
905	2014038073251	01/24/14	- 01/31/14	02/17/14	0.00	1,375.00	0.00	0.00
905	2014038073493	01/17/14	- 01/24/14	02/17/14	0.00	550.00	0.00	0.00
905	2014043060631	02/02/14	- 02/04/14	02/17/14	0.00	550.00	0.00	0.00
905	2014043060671	01/24/14	- 02/05/14	02/17/14	0.00	275.00	0.00	0.00
905	2014043060677	02/01/14	- 02/05/14	02/17/14	0.00	1,650.00	0.00	0.00
905	2014043060748	01/30/14	- 02/03/14	02/17/14	0.00	550.00	0.00	0.00
905	2014043060781	01/24/14	- 02/04/14	02/17/14	0.00	1,375.00	0.00	0.00
905	2014045053465	01/21/14	- 02/06/14	02/24/14	0.00	2,200.00	0.00	0.00
905	2014049065930	02/07/14	- 02/11/14	02/24/14	0.00	275.00	0.00	0.00
905	2014049065938	02/01/14	- 02/11/14	02/24/14	0.00	2,750.00	0.00	0.00
905	2014049066028	02/09/14	- 02/11/14	02/24/14	0.00	275.00	0.00	0.00
905	2014049066065	01/24/14	- 01/30/14	02/24/14	0.00	825.00	0.00	0.00
905	2014049066076	02/07/14	- 02/11/14	02/24/14	0.00	275.00	0.00	0.00
905	2014050048070	02/07/14	- 02/14/14	02/24/14	0.00	825.00	0.00	0.00
905	2014050048092	02/08/14	- 02/14/14	02/24/14	0.00	825.00	0.00	0.00
905	2014050048101	02/06/14	- 02/14/14	02/24/14	0.00	825.00	0.00	0.00
905	2014051084622	02/04/14	- 02/11/14	02/24/14	0.00	1,100.00	0.00	0.00
905	2014051084906	02/04/14	- 02/14/14	02/24/14	0.00	550.00	0.00	0.00
905	2014052078100	01/22/14	- 01/31/14	03/03/14	0.00	550.00	0.00	0.00
905	2014058078363	02/10/14	- 02/17/14	03/03/14	0.00	2,200.00	0.00	0.00
905	2014058078407	02/20/14	- 02/22/14	03/03/14	0.00	275.00	0.00	0.00
905	2014058078509	02/13/14	- 02/18/14	03/03/14	0.00	550.00	0.00	0.00
905	2014058078528	02/08/14	- 02/18/14	03/03/14	0.00	1,100.00	0.00	0.00
905	2014058078530	02/12/14	- 02/18/14	03/03/14	0.00	825.00	0.00	0.00
905	2014058078577	02/20/14	- 02/22/14	03/03/14	0.00	1,100.00	0.00	0.00
905	2014058078605	01/25/14	- 01/28/14	03/03/14	0.00	825.00	0.00	0.00
905	2014058078613	02/17/14	- 02/19/14	03/03/14	0.00	275.00	0.00	0.00
905	2014059090056	02/15/14	- 02/19/14	03/10/14	0.00	825.00	0.00	0.00
905	2014062046968	02/11/14	- 02/18/14	03/10/14	0.00	550.00	0.00	0.00
905	2014062047035	02/08/14	- 02/17/14	03/10/14	0.00	825.00	0.00	0.00
905	2014062047202	02/15/14	- 02/19/14	03/10/14	0.00	1,100.00	0.00	0.00
905	2014065083528	02/24/14	- 02/26/14	03/10/14	0.00	550.00	0.00	0.00
905	2014065083764	02/21/14	- 02/25/14	03/10/14	0.00	1,375.00	0.00	0.00
905	2014066057793	02/18/14	- 02/25/14	03/17/14	0.00	1,100.00	0.00	0.00
615	2014066057833	02/23/14	- 02/25/14	03/17/14	0.00	6,862.00	0.00	0.00
905	2014066057873	02/18/14	- 02/26/14	03/17/14	0.00	275.00	0.00	0.00
905	2014066057985	02/21/14	- 02/28/14	03/17/14	0.00	275.00	0.00	0.00
905	2014070055374	03/01/14	- 03/06/14	03/17/14	0.00	550.00	0.00	0.00
905	2014070055389	03/01/14	- 03/06/14	03/17/14	0.00	1,100.00	0.00	0.00
905	2014070055398	02/28/14	- 03/05/14	03/17/14	0.00	1,375.00	0.00	0.00
905	2014071072332	12/07/13	- 12/16/13	03/17/14	0.00	1,100.00	0.00	0.00
905	2014071072461	02/18/14	- 02/24/14	03/17/14	0.00	825.00	0.00	0.00

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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CLM	CLM	CLM	CLM	CLM	CLM	CLM	CLM	CLM
905	2014072067185	01/05/14 - 01/08/14	03/17/14	0.00	275.00	0.00	0.00	0.00
905	2014073067894	03/06/14 - 03/07/14	03/24/14	0.00	825.00	0.00	0.00	0.00
905	2014073067904	03/05/14 - 03/05/14	03/24/14	0.00	275.00	0.00	0.00	0.00
905	2014073067908	02/08/14 - 02/14/14	03/24/14	0.00	1,925.00	0.00	0.00	0.00
905	2014076037210	02/03/14 - 02/10/14	03/24/14	0.00	275.00	0.00	0.00	0.00
905	2014079098207	03/05/14 - 03/10/14	03/24/14	0.00	1,650.00	0.00	0.00	0.00
905	2014079098271	03/05/14 - 03/11/14	03/24/14	0.00	275.00	0.00	0.00	0.00
905	2014079098401	03/08/14 - 03/13/14	03/24/14	0.00	1,650.00	0.00	0.00	0.00
905	2014079098403	03/10/14 - 03/13/14	03/24/14	0.00	275.00	0.00	0.00	0.00
905	2014079098483	03/05/14 - 03/10/14	03/24/14	0.00	1,375.00	0.00	0.00	0.00
905	2014079098544	03/06/14 - 03/11/14	03/24/14	0.00	550.00	0.00	0.00	0.00
905	2014080081510	02/24/14 - 03/10/14	03/31/14	0.00	1,375.00	0.00	0.00	0.00
905	2014080081526	03/02/14 - 03/11/14	03/31/14	0.00	1,650.00	0.00	0.00	0.00
905	2014083038591	03/12/14 - 03/17/14	03/31/14	0.00	1,375.00	0.00	0.00	0.00
905	2014083038673	02/07/14 - 02/14/14	03/31/14	0.00	550.00	0.00	0.00	0.00
905	2014083038940	02/05/14 - 02/14/14	03/31/14	0.00	275.00	0.00	0.00	0.00
905	2014083038955	03/02/14 - 03/07/14	03/31/14	0.00	1,650.00	0.00	0.00	0.00
905	2014084066064	03/13/14 - 03/18/14	03/31/14	0.00	1,100.00	0.00	0.00	0.00
905	2014084066224	03/14/14 - 03/19/14	03/31/14	0.00	825.00	0.00	0.00	0.00
905	2014084066234	03/08/14 - 03/12/14	03/31/14	0.00	550.00	0.00	0.00	0.00
905	2014084066305	03/10/14 - 03/14/14	03/31/14	0.00	550.00	0.00	0.00	0.00
905	2014091062631	03/20/14 - 03/26/14	04/07/14	0.00	1,650.00	0.00	0.00	0.00
905	2014093090357	03/21/14 - 03/28/14	04/07/14	0.00	550.00	0.00	0.00	0.00
905	2014093090439	03/24/14 - 03/28/14	04/07/14	0.00	275.00	0.00	0.00	0.00
905	2014093090452	03/25/14 - 03/28/14	04/07/14	0.00	550.00	0.00	0.00	0.00
905	2014097043170	03/25/14 - 03/31/14	04/14/14	0.00	550.00	0.00	0.00	0.00
905	2014097043176	03/18/14 - 03/31/14	04/14/14	0.00	3,025.00	0.00	0.00	0.00
905	2014099087075	03/26/14 - 04/02/14	04/14/14	0.00	275.00	0.00	0.00	0.00
905	2014099087154	03/22/14 - 04/01/14	04/14/14	0.00	1,100.00	0.00	0.00	0.00
905	2014099087173	03/27/14 - 04/01/14	04/14/14	0.00	825.00	0.00	0.00	0.00
905	2014099087228	03/28/14 - 04/01/14	04/14/14	0.00	550.00	0.00	0.00	0.00
905	2014099087299	03/24/14 - 03/29/14	04/14/14	0.00	1,100.00	0.00	0.00	0.00
905	2014100072773	04/02/14 - 04/04/14	04/14/14	0.00	550.00	0.00	0.00	0.00
615	2214106000377	09/29/13 - 10/10/13	04/21/14	0.00	6,862.00	0.00	0.00	0.00
615	2314108000175	12/14/13 - 12/23/13	05/12/14	0.00	6,862.00	0.00	0.00	0.00
905	2014115085146	02/08/14 - 02/14/14	05/05/14	0.00	825.00	0.00	0.00	0.00
905	2014134043455	04/03/14 - 04/06/14	05/19/14	0.00	275.00	0.00	0.00	0.00
905	2014148053549	07/02/13 - 07/05/13	06/02/14	0.00	550.00	0.00	0.00	0.00
905	2014148053569	03/22/14 - 04/01/14	06/02/14	0.00	1,650.00	0.00	0.00	0.00
905	2014160030066	12/06/13 - 12/10/13	06/16/14	0.00	550.00	0.00	0.00	0.00
615	5914202000011	03/06/14 - 03/08/14	07/28/14	0.00	3,498.00	0.00	0.00	0.00
905	2214231014468	03/24/14 - 03/27/14	08/25/14	0.00	825.00	0.00	0.00	0.00
905	2014232006816	03/31/14 - 04/07/14	08/25/14	0.00	550.00	0.00	0.00	0.00
615	5215071000041	09/08/13 - 12/07/13	03/16/15	0.00	7,755.00	0.00	0.00	0.00
905	2315140000206	04/01/14 - 04/08/14	06/01/15	0.00	1,100.00	0.00	38.56	0.00
615	2215146004911	01/31/14 - 02/03/14	06/01/15	0.00	7,755.00	0.00	0.00	0.00

Report : CLM-0800-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:57:05
Page: 10

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

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

TOTAL	0.00	317,375.00	0.00	38.56	0.00
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Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 00:57:18
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WELLSTAR COBB HOSPITAL
 3950 AUSTELL RD
 AUSTELL,GA 30106-1121

PROVIDER NUMBER 000000426A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,063.74	ADJUSTMENTS	0.00
COVERED CHARGES	10,962.74	CONTRACTUAL ALLOW	3,121.48
NON-COVERD CHARGES	101.00	TOTAL MEDICAID LIAB	7,841.26
		LESS: COB	7,841.26
		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	1,014.00	101.00
ROUTINE NURSERY	0	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	1,014.00	101.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	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	1,014.00	101.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	490.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	393.99	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	470.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	8,368.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	226.00	0.00			
			TOTAL ANCILLARY	9,948.74	0.00
			TOTAL ACCOMODATIONS	1,014.00	101.00
			TOTAL CHARGES	10,962.74	101.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:57:21
Page: 13

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

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,504,486.33	ADJUSTMENTS	919,944.82
COVERED CHARGES	22,709,601.84	CONTRACTUAL ALLOW	18,356,892.78
NON-COVERD CHARGES	3,794,884.49	TOTAL MEDICAID LIAB	4,352,709.06
		LESS: COB	8,516.70
		LESS: COPAYMENT	7,102.13
		REIMBURSEMENT	4,337,090.23
		ALL OTHER	3,762,082.00
		FEE SCHEDULE-LAB	381,466.13
		INJECTABLE DRUGS	193,542.10

TOTAL NUMBER OF CLAIMS 9,733

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

PROVIDER NUMBER
 000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	415,175.73	63,109.50	OTHER LAB	555,461.00	459.00
MED/SURG SUPPLY	414,060.83	54,761.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,394.00	EDUCATION & TRAINING	358.00	281.00
RADIOLOGY-DIAGNOSTIC	1,250,616.00	12,446.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,072,186.00	717,729.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	18,719.00	43,998.00	FEE SCHEDULE LAB	4,034,269.06	551,873.72
EKG/ECG	357,109.00	5,820.00	MRI SERVICES	540,022.00	83,805.00
IV THERAPY	630,982.00	355,927.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,406,400.00	268,953.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	361,960.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	189,528.56	61,872.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	609,562.00	611.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,472,493.00	65,618.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	662,938.00	2,911.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	987,702.25	842,488.25
RADIOLOGY THERAPEUTIC	131,240.00	1,271.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,949.00	20,067.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,781.00	12,248.05	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	78,470.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	247,939.00	11,078.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	173,661.00	47,609.00	IMPL DEV CHARGE PATIENTS	67,587.39	160,525.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	841,997.00	174,380.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	48,036.00	8,784.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	471,863.00	33,089.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	418,590.00	62,964.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	9,886.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	308,530.02	50,342.72			
			TOTAL ANCILLARY	22,709,601.84	3,794,884.49
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	22,709,601.84	3,794,884.49

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	186,550.37	ADJUSTMENTS	0.00
COVERED CHARGES	170,308.34	CONTRACTUAL ALLOW	105,410.46
NON-COVERD CHARGES	16,242.03	TOTAL MEDICAID LIAB	64,897.88
		LESS: COB	64,876.35
		LESS: COPAYMENT	21.53
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 50

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,754.50	0.00	OTHER LAB	2,044.00	0.00
MED/SURG SUPPLY	1,915.23	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,020.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,070.00	5,386.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	31,210.00	1,729.28
EKG/ECG	2,716.00	0.00	MRI SERVICES	8,808.00	0.00
IV THERAPY	4,070.00	1,826.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,190.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,494.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	893.00	921.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,817.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	35,847.00	105.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,742.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,502.25	1,792.75
RADIOLOGY THERAPEUTIC	1,116.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	804.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,787.00	4,482.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,734.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,576.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,869.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,329.36	0.00			
			TOTAL ANCILLARY	170,308.34	16,242.03
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	170,308.34	16,242.03

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:58:00
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WELLSTAR COBB HOSPITAL
3950 AUSTELL RD
AUSTELL,GA 30106-1121

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,574,242.66	ADJUSTMENTS	3,003.63
COVERED CHARGES	2,337,474.95	CONTRACTUAL ALLOW	2,254,347.12
NON-COVERD CHARGES	236,767.71	TOTAL MEDICAID LIAB	83,127.83
		LESS: COB	0.00
		LESS: COPAYMENT	2,190.08
		REIMBURSEMENT	80,937.75
		TOTAL NUMBER OF CLAIMS	1,487

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,530.49	3,717.00	OTHER LAB	88,390.00	459.00
MED/SURG SUPPLY	7,320.71	416.21	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	147,143.00	422.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	57,694.00	91,737.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	466,665.00	27,227.00
EKG/ECG	28,324.00	0.00	MRI SERVICES	38,529.00	10,324.00
IV THERAPY	65,860.00	34,438.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,442.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	14,330.00	2,166.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,276,019.00	2,183.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	26,719.75	2,454.50
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	28,025.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	100.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	20,904.00	560.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	64,604.00	32,539.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,337,474.95	236,767.71
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,337,474.95	236,767.71

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 00:58:07
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	154.00	120.00	OTHER LAB	1,438.00	0.00
MED/SURG SUPPLY	62.00	61.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	542.00	0.00	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	3,779.00	137.00
EKG/ECG	388.00	0.00	MRI SERVICES	5,857.00	0.00
IV THERAPY	1,687.00	86.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	218.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,472.00	35.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	175.00	23.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	402.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPTY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	621.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	23,174.00	3,776.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	23,174.00	3,776.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,973,322.65	ADJUSTMENTS	143,267.74
COVERED CHARGES	2,573,608.94	CONTRACTUAL ALLOW	2,197,060.24
NON-COVERD CHARGES	399,713.71	TOTAL MEDICAID LIAB	376,548.70
		LESS: COB	0.00
		LESS: COPAYMENT	471.00
		REIMBURSEMENT	376,077.70
		TOTAL NUMBER OF CLAIMS	70

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47,161.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	149,247.82	27,702.73	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,890.00	198.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,361.00	5,726.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	338.00	FEE SCHEDULE LAB	43,417.00	1,644.00
EKG/ECG	3,492.00	388.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,276.00	24,282.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	453,117.00	72,218.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	547.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	193,126.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,034.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	116,198.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,104,839.50	236,696.00
RADIOLOGY THERAPEUTIC	65,846.00	616.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	382.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,918.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	291,743.56	24,048.82
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	21,006.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	13,124.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,132.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,624.00	4,758.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	23,508.31	716.16			
			TOTAL ANCILLARY	2,573,608.94	399,713.71
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,573,608.94	399,713.71

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 00:58:24
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

TY COBB REGIONAL MEDICAL CENTER LLC
 367 CLEAR CREEK PARKWAY
 LAVONIA,GA 30553-4173

PROVIDER NUMBER 000000437A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,736,325.96	ADJUSTMENTS	107,653.22
COVERED CHARGES	2,730,247.96	CONTRACTUAL ALLOW	1,534,436.60
NON-COVERD CHARGES	6,078.00	TOTAL MEDICAID LIAB	1,195,811.36
		LESS: COB	12,784.17
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,183,027.19

TOTAL NUMBER OF ADMISSIONS 212

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	455		0	199,286.00		459.00
ROUTINE NURSERY	103		3	26,057.00		843.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	558		3	225,343.00		1,302.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	129		0	119,803.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	119,803.00		0.00
TOTAL ACCOMODATIONS	687		3	345,146.00		1,302.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

TY COBB REGIONAL MEDICAL CENTER LLC
 367 CLEAR CREEK PARKWAY
 LAVONIA,GA 30553-4173

PROVIDER NUMBER
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	279,991.46	0.00	OTHER LAB	6,672.00	0.00
MED/SURG SUPPLY	238,225.37	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	371,799.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,184.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	138,377.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	30,234.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	16,800.00	0.00	MRI SERVICES	10,952.00	0.00
IV THERAPY	4,899.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	80,031.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	143,384.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	231,526.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	16,116.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	156,020.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,462.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	6,498.00	0.00	INJECTABLE DRUGS	478,685.13	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,379.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	10,565.00	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	146.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	17,946.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	932.00
OTHER IMAGING SERVICE	14,741.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,022.00	658.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,864.00	3,186.00			
AUDIOLOGY	2,162.00	0.00			
CARDIOLOGY	26,537.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,895.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	23,989.00	0.00			
			TOTAL ANCILLARY	2,385,101.96	4,776.00
			TOTAL ACCOMODATIONS	345,146.00	1,302.00
			TOTAL CHARGES	2,730,247.96	6,078.00

Report : CLM-0800-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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TY COBB REGIONAL MEDICAL CENTER LLC
367 CLEAR CREEK PARKWAY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014091057625	03/20/14 - 03/25/14	04/07/14	0.00	233.00	0.00	0.00	0.00
614	2014118026990	04/02/14 - 04/10/14	05/05/14	0.00	233.00	0.00	0.00	0.00
614	2014128000982	04/09/14 - 04/14/14	05/12/14	0.00	466.00	0.00	0.00	0.00
TOTAL				0.00	932.00	0.00	0.00	0.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 00:58:26
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SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

TY COBB REGIONAL MEDICAL CENTER LLC
 367 CLEAR CREEK PARKWAY
 LAVONIA,GA 30553-4173

PROVIDER NUMBER
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	68,918.86	ADJUSTMENTS	0.00
COVERED CHARGES	68,848.86	CONTRACTUAL ALLOW	22,321.49
NON-COVERD CHARGES	70.00	TOTAL MEDICAID LIAB	46,527.37
		LESS: COB	46,527.37
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	16		0	7,024.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	16		0	7,024.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	2		0	2,098.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	2,098.00		0.00
TOTAL ACCOMODATIONS	18		0	9,122.00		0.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

TY COBB REGIONAL MEDICAL CENTER LLC
 367 CLEAR CREEK PARKWAY
 LAVONIA,GA 30553-4173

PROVIDER NUMBER
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,945.86	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,191.00	70.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,470.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,423.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,192.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,794.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	320.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,172.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,391.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,863.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,107.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	275.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	33.00	0.00	INJECTABLE DRUGS	7,096.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,117.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,337.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	59,726.86	70.00
			TOTAL ACCOMODATIONS	9,122.00	0.00
			TOTAL CHARGES	68,848.86	70.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:58:27
Page: 6

TY COBB REGIONAL MEDICAL CENTER LLC
367 CLEAR CREEK PARKWAY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,815,382.23	ADJUSTMENTS	146,221.90
COVERED CHARGES	3,469,853.20	CONTRACTUAL ALLOW	2,476,232.99
NON-COVERD CHARGES	345,529.03	TOTAL MEDICAID LIAB	993,620.21
		LESS: COB	428.34
		LESS: COPAYMENT	2,641.08
		REIMBURSEMENT	990,550.79
		ALL OTHER	896,590.63
		FEE SCHEDULE-LAB	81,503.00
		INJECTABLE DRUGS	12,457.16
		TOTAL NUMBER OF CLAIMS	2,512

TY COBB REGIONAL MEDICAL CENTER LLC
 367 CLEAR CREEK PARKWAY
 LAVONIA,GA 30553-4173

PROVIDER NUMBER
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	76,447.75	21,365.97	OTHER LAB	31,494.00	0.00
MED/SURG SUPPLY	130,443.15	29,775.20	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	520.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	164,635.00	1,013.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	556,165.00	49,948.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,384.00	2,605.00	FEE SCHEDULE LAB	631,494.80	80,782.20
EKG/ECG	42,955.00	0.00	MRI SERVICES	49,475.00	2,944.00
IV THERAPY	125,866.00	7,621.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	116,988.00	16,132.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,712.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	39,775.00	1,536.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1.00	222.00	AMBULANCE	0.00	0.00
GI SERVICES	162,951.50	22,062.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	718,850.00	5,215.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	40,607.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	1,077.00	INJECTABLE DRUGS	129,400.00	49,494.16
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	122.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,660.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	4,526.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	24,825.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,917.00
OTHER IMAGING SERVICE	140,022.00	6,618.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,220.00	2,365.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	108,496.00	33,321.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	67,885.00	1,337.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	39,192.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	64,569.00	350.00			
			TOTAL ANCILLARY	3,469,853.20	345,529.03
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,469,853.20	345,529.03

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

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TY COBB REGIONAL MEDICAL CENTER LLC
367 CLEAR CREEK PARKWAY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014072051433	03/05/14 - 03/05/14	03/17/14	0.00	233.00	0.00	0.00	0.00
614	2014086065614	03/21/14 - 03/21/14	03/31/14	0.00	233.00	0.00	0.00	0.00
618	5914118000769	04/15/14 - 04/15/14	05/05/14	0.00	1,985.00	0.00	0.00	0.00
614	2014162067417	06/03/14 - 06/03/14	06/16/14	0.00	233.00	0.00	0.00	0.00
614	5914211000386	06/23/14 - 06/23/14	08/04/14	0.00	233.00	0.00	0.00	0.00
TOTAL				0.00	2,917.00	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TY COBB REGIONAL MEDICAL CENTER LLC
367 CLEAR CREEK PARKWAY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	67,010.48	ADJUSTMENTS	0.00
COVERED CHARGES	50,789.10	CONTRACTUAL ALLOW	12,749.62
NON-COVERD CHARGES	16,221.38	TOTAL MEDICAID LIAB	38,039.48
		LESS: COB	38,011.15
		LESS: COPAYMENT	28.33
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 48

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TY COBB REGIONAL MEDICAL CENTER LLC
 367 CLEAR CREEK PARKWAY
 LAVONIA,GA 30553-4173

PROVIDER NUMBER
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,023.00	377.88	OTHER LAB	1,262.00	0.00
MED/SURG SUPPLY	2,282.60	761.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,506.00	171.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,518.00	5,036.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,324.00	FEE SCHEDULE LAB	7,091.00	2,158.00
EKG/ECG	320.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	691.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,640.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	299.00	192.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,042.50	2,640.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,930.00	1,361.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	916.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,239.00	572.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,186.00	580.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,277.00	698.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,079.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	487.00	350.00			
			TOTAL ANCILLARY	50,789.10	16,221.38
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	50,789.10	16,221.38

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

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TY COBB REGIONAL MEDICAL CENTER LLC
367 CLEAR CREEK PARKWAY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	240,513.80	ADJUSTMENTS	691.22
COVERED CHARGES	230,189.00	CONTRACTUAL ALLOW	213,071.37
NON-COVERD CHARGES	10,324.80	TOTAL MEDICAID LIAB	17,117.63
		LESS: COB	0.00
		LESS: COPAYMENT	570.00
		REIMBURSEMENT	16,547.63
		TOTAL NUMBER OF CLAIMS	306

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

TY COBB REGIONAL MEDICAL CENTER LLC
 367 CLEAR CREEK PARKWAY
 LAVONIA,GA 30553-4173

PROVIDER NUMBER
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,789.00	267.00	OTHER LAB	1,262.00	0.00
MED/SURG SUPPLY	2,764.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,162.00	708.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,164.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	950.00	FEE SCHEDULE LAB	40,966.00	5,230.00
EKG/ECG	1,440.00	0.00	MRI SERVICES	1,649.00	0.00
IV THERAPY	6,883.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,591.00	96.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	125,083.00	424.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,476.00	2,124.80
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	292.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	233.00
OTHER IMAGING SERVICE	5,703.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,337.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,920.00	0.00			
			TOTAL ANCILLARY	230,189.00	10,324.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	230,189.00	10,324.80

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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TY COBB REGIONAL MEDICAL CENTER LLC
367 CLEAR CREEK PARKWAY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2214279009364	04/10/14 - 04/10/14	10/13/14	0.00	233.00	0.00	0.00	0.00
TOTAL				0.00	233.00	0.00	0.00	0.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TY COBB REGIONAL MEDICAL CENTER LLC
367 CLEAR CREEK PARKWAY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,862.00	ADJUSTMENTS	0.00
COVERED CHARGES	7,810.00	CONTRACTUAL ALLOW	3,190.82
NON-COVERD CHARGES	3,052.00	TOTAL MEDICAID LIAB	4,619.18
		LESS: COB	4,613.18
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	7

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

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SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TY COBB REGIONAL MEDICAL CENTER LLC
 367 CLEAR CREEK PARKWAY
 LAVONIA,GA 30553-4173

PROVIDER NUMBER
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	96.00	57.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	541.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,518.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,219.00	319.00
EKG/ECG	320.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,637.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	286.00	158.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	711.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,810.00	3,052.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,810.00	3,052.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TY COBB REGIONAL MEDICAL CENTER LLC
367 CLEAR CREEK PARKWAY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,109.29	ADJUSTMENTS	0.00
COVERED CHARGES	18,432.29	CONTRACTUAL ALLOW	12,976.63
NON-COVERD CHARGES	2,677.00	TOTAL MEDICAID LIAB	5,455.66
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,455.66

TOTAL NUMBER OF CLAIMS 1

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TY COBB REGIONAL MEDICAL CENTER LLC
 367 CLEAR CREEK PARKWAY
 LAVONIA,GA 30553-4173

PROVIDER NUMBER
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	583.00	287.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,592.29	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	929.00	578.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,046.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,126.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	979.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	275.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,316.00	191.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	711.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	915.00	1,621.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	960.00	0.00			
			TOTAL ANCILLARY	18,432.29	2,677.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,432.29	2,677.00

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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Page: 18

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TY COBB REGIONAL MEDICAL CENTER LLC
367 CLEAR CREEK PARKWAY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 00:58:47
 Page: 1

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,602,471.03	ADJUSTMENTS	403,055.34
COVERED CHARGES	13,245,470.03	CONTRACTUAL ALLOW	8,618,531.59
NON-COVERD CHARGES	357,001.00	TOTAL MEDICAID LIAB	4,626,938.44
		LESS: COB	85,399.58
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,541,538.86

TOTAL NUMBER OF ADMISSIONS 558

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,657		33	993,765.00		150,359.00
ROUTINE NURSERY	72		0	40,214.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,729		33	1,033,979.00		150,359.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	346		0	426,745.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	346		0	426,745.00		0.00
TOTAL ACCOMODATIONS	2,075		33	1,460,724.00		150,359.00

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 00:58:47
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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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,590,109.00	19,404.00	OTHER LAB	44,264.00	542.00
MED/SURG SUPPLY	582,257.00	7,958.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,239,016.00	5,271.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	278,026.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	550,203.00	13,479.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	160,244.06	11,628.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	271,809.00	932.00	MRI SERVICES	98,620.00	0.00
IV THERAPY	211,441.00	306.00	PROFESSIONAL FEES	0.00	230.00
OPERATING ROOM	2,104,837.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	39,475.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	781,567.00	8,107.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	212,859.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	143,408.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	300,319.00	701.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	63,665.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	34,487.00
LABORATORY PATHOLOGIC	25,829.00	0.00	INJECTABLE DRUGS	37,608.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,067.03	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	49,614.00	3,752.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,592.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,280,380.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	8,085.00
OTHER IMAGING SERVICE	42,298.00	0.00			
BLOOD	3,387.00	0.00			
BLOOD STORAGE & PRO.	61,364.00	90,740.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	100,828.00	1,020.00			
AUDIOLOGY	3,195.00	0.00			
CARDIOLOGY	314,100.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	10,587.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	178,777.94	0.00			
			TOTAL ANCILLARY	11,784,746.03	206,642.00
			TOTAL ACCOMODATIONS	1,460,724.00	150,359.00
			TOTAL CHARGES	13,245,470.03	357,001.00

Report : CLM-0800-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5215033000010	03/09/14 - 05/27/14	02/09/15	0.00	2,695.00	0.00	0.00	0.00
615	2215037022955	11/12/14 - 11/18/14	02/09/15	0.00	2,695.00	0.00	0.00	0.00
615	2315048000225	11/15/14 - 11/18/14	03/09/15	0.00	2,695.00	0.00	1,656.66	0.00
TOTAL				0.00	8,085.00	0.00	1,656.66	0.00

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	131,612.00	ADJUSTMENTS	0.00
COVERED CHARGES	129,793.00	CONTRACTUAL ALLOW	40,132.48
NON-COVERD CHARGES	1,819.00	TOTAL MEDICAID LIAB	89,660.52
		LESS: COB	89,660.52
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	11		0	6,875.00		917.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	11		0	6,875.00		917.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	4		0	4,400.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	4		0	4,400.00		0.00
TOTAL ACCOMODATIONS	15		0	11,275.00		917.00

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,380.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,818.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,611.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,138.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,594.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	934.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,123.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,166.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	43,730.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,353.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,968.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,356.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	701.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,380.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	756.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	22,567.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	537.00	902.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,403.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,003.00	0.00			
			TOTAL ANCILLARY	118,518.00	902.00
			TOTAL ACCOMODATIONS	11,275.00	917.00
			TOTAL CHARGES	129,793.00	1,819.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 00:58:55
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,805,813.17	ADJUSTMENTS	770,058.06
COVERED CHARGES	10,355,252.30	CONTRACTUAL ALLOW	8,317,394.38
NON-COVERD CHARGES	450,560.87	TOTAL MEDICAID LIAB	2,037,857.92
		LESS: COB	19,450.24
		LESS: COPAYMENT	6,278.13
		REIMBURSEMENT	2,012,129.55
		ALL OTHER	1,817,499.01
		FEE SCHEDULE-LAB	178,274.56
		INJECTABLE DRUGS	16,355.98

TOTAL NUMBER OF CLAIMS 5,138

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	437,160.00	1,030.00	OTHER LAB	51,721.00	0.00
MED/SURG SUPPLY	273,027.00	424.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	388,043.00	2,503.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	986,084.00	84,975.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	31,197.00	18,311.13	FEE SCHEDULE LAB	1,927,911.29	150,776.70
EKG/ECG	148,815.00	5,874.00	MRI SERVICES	293,121.00	8,333.00
IV THERAPY	522,061.00	56,349.00	PROFESSIONAL FEES	0.00	89.00
OPERATING ROOM	1,636,641.04	32,895.96	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	21,988.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	147,155.00	14,667.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	316,507.00	812.00	AMBULANCE	0.00	0.00
GI SERVICES	231,311.01	10,481.99	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,294,960.01	703.01	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	77,945.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	90,622.00	7,477.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	542.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	702.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	273,526.00	5,678.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	67,224.00	978.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	218,329.00	14,299.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,127.00	5,412.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	289,509.00	10,902.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	270,318.00	12,714.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	20,408.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	337,541.95	3,632.08			
			TOTAL ANCILLARY	10,355,252.30	450,560.87
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,355,252.30	450,560.87

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	190,762.08	ADJUSTMENTS	0.00
COVERED CHARGES	166,755.68	CONTRACTUAL ALLOW	79,015.80
NON-COVERD CHARGES	24,006.40	TOTAL MEDICAID LIAB	87,739.88
		LESS: COB	87,712.88
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 97

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,870.00	28.00	OTHER LAB	2,385.00	0.00
MED/SURG SUPPLY	6,622.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,523.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,965.00	4,467.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	23,641.00	1,968.00
EKG/ECG	890.00	178.00	MRI SERVICES	5,298.00	0.00
IV THERAPY	9,063.00	153.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	34,729.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,201.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,543.00	1,236.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,168.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,504.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	26,972.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,785.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,014.00	189.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,349.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	463.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,976.00	2,041.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	13,216.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,794.68	530.40			
			TOTAL ANCILLARY	166,755.68	24,006.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	166,755.68	24,006.40

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	605,119.05	ADJUSTMENTS	2,197.54
COVERED CHARGES	588,849.05	CONTRACTUAL ALLOW	540,879.70
NON-COVERD CHARGES	16,270.00	TOTAL MEDICAID LIAB	47,969.35
		LESS: COB	2,888.18
		LESS: COPAYMENT	1,296.00
		REIMBURSEMENT	43,785.17
		TOTAL NUMBER OF CLAIMS	809

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,434.00	131.00	OTHER LAB	555.00	0.00
MED/SURG SUPPLY	4,623.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	30,012.00	632.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	32,049.00	5,857.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	121,613.00	4,547.00
EKG/ECG	6,586.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	39,028.00	3,366.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,556.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,346.00	259.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	306,247.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,236.00	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	5,283.00	566.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	813.00	902.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,468.05	0.00			
			TOTAL ANCILLARY	588,849.05	16,270.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	588,849.05	16,270.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,601.00	ADJUSTMENTS	0.00
COVERED CHARGES	10,578.00	CONTRACTUAL ALLOW	5,269.81
NON-COVERD CHARGES	23.00	TOTAL MEDICAID LIAB	5,308.19
		LESS: COB	5,302.17
		LESS: COPAYMENT	6.02
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	11

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	197.00	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	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,895.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,886.98	23.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	162.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,914.02	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	56.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	421.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	10,578.00	23.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,578.00	23.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,084,305.94	ADJUSTMENTS	230,078.38
COVERED CHARGES	2,034,891.74	CONTRACTUAL ALLOW	1,691,099.76
NON-COVERD CHARGES	49,414.20	TOTAL MEDICAID LIAB	343,791.98
		LESS: COB	0.00
		LESS: COPAYMENT	189.00
		REIMBURSEMENT	343,602.98
		TOTAL NUMBER OF CLAIMS	61

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,524.00	0.00	OTHER LAB	1,250.00	0.00
MED/SURG SUPPLY	21,060.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,801.00	14,537.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,148.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,620.00	FEE SCHEDULE LAB	12,697.00	492.00
EKG/ECG	534.00	890.00	MRI SERVICES	0.00	0.00
IV THERAPY	324.00	459.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,369,946.22	943.20	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,254.00	132.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	125,963.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	701.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	33,915.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,742.00	215.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	354,228.00	1,980.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	638.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,460.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	31,373.00	4,376.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,333.52	22,770.00			
			TOTAL ANCILLARY	2,034,891.74	49,414.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,034,891.74	49,414.20

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 00:59:32
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	32,717,718.29	ADJUSTMENTS	1,267,010.58
COVERED CHARGES	31,653,960.54	CONTRACTUAL ALLOW	23,932,329.29
NON-COVERD CHARGES	1,063,757.75	TOTAL MEDICAID LIAB	7,721,631.25
		LESS: COB	37,707.44
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,683,923.81

TOTAL NUMBER OF ADMISSIONS 811

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,970		2	2,604,690.00		675,470.00
ROUTINE NURSERY	166		1	249,377.00		642.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,136		3	2,854,067.00		676,112.00
SPECIAL CARE SERVICES						
CCU	237		0	391,429.00		0.00
ICU	743		3	1,562,818.00		4,248.00
NICU	139		0	523,323.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,119		3	2,477,570.00		4,248.00
TOTAL ACCOMODATIONS	4,255		6	5,331,637.00		680,360.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,636,394.10	351.25	OTHER LAB	158,882.00	0.00
MED/SURG SUPPLY	1,034,236.00	1,557.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,896,867.75	52.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	900,779.75	0.00	OTHER THERAPEUTIC SVC	0.00	711.75
CT SCAN	1,211,109.75	255,461.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	695,907.19	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	199,795.00	0.00	MRI SERVICES	393,352.00	0.00
IV THERAPY	57,920.00	1,372.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,015,731.00	551.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	279,231.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,076,149.75	2,826.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	433,791.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	100,788.25	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	830,764.50	1,604.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	429,626.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	95,467.25
LABORATORY PATHOLOGIC	95,346.00	0.00	INJECTABLE DRUGS	5,330,788.25	0.75
RADIOLOGY THERAPEUTIC	12,251.25	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	606,479.96	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	191,200.04	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	251,309.00	4,006.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,020.50	187.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	478,162.50	0.00
LITHOTRIPSY	7,170.50	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	234,641.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	307,453.25	3,078.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	89,900.50	16,170.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,307,432.25	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	25,353.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	27,488.00	0.00			
			TOTAL ANCILLARY	26,322,323.54	383,397.75
			TOTAL ACCOMODATIONS	5,331,637.00	680,360.00
			TOTAL CHARGES	31,653,960.54	1,063,757.75

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	232,813.00	ADJUSTMENTS	0.00
COVERED CHARGES	199,650.00	CONTRACTUAL ALLOW	139,401.86
NON-COVERD CHARGES	33,163.00	TOTAL MEDICAID LIAB	60,248.14
		LESS: COB	60,248.14
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 12

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	28		0	23,679.00		2,117.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	28		0	23,679.00		2,117.00
SPECIAL CARE SERVICES						
CCU	1		0	0.00		1,242.00
ICU	2		0	0.00		4,052.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	0.00		5,294.00
TOTAL ACCOMODATIONS	31		0	23,679.00		7,411.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,736.75	1,368.50	OTHER LAB	561.00	0.00
MED/SURG SUPPLY	2,087.00	2,582.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	18,030.25	9,616.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	516.50	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	0.00	0.00
EKG/ECG	0.00	712.50	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	23,270.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	57,370.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	2,237.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,367.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	1,580.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	36,159.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,482.00	0.00	INJECTABLE DRUGS	22,504.50	2,814.50
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	1,202.00	1,173.50			
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	3,151.00			
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	1,200.00	0.00			
			TOTAL ANCILLARY	175,971.00	25,752.00
			TOTAL ACCOMODATIONS	23,679.00	7,411.00
			TOTAL CHARGES	199,650.00	33,163.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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COLISEUM MEDICAL CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,449,862.70	ADJUSTMENTS	101,428.82
COVERED CHARGES	11,007,986.70	CONTRACTUAL ALLOW	9,091,776.39
NON-COVERD CHARGES	1,441,876.00	TOTAL MEDICAID LIAB	1,916,210.31
		LESS: COB	2,864.40
		LESS: COPAYMENT	1,381.80
		REIMBURSEMENT	1,911,964.11
		ALL OTHER	1,730,952.80
		FEE SCHEDULE-LAB	139,183.01
		INJECTABLE DRUGS	41,828.30

TOTAL NUMBER OF CLAIMS 3,563

COLISEUM MEDICAL CENTERS
 350 HOSPITAL DR
 MACON,GA 31217-3838

PROVIDER NUMBER
 000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	253,995.75	1,101.50	OTHER LAB	96,573.50	0.00
MED/SURG SUPPLY	144,110.25	2,367.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	872,235.25	8,411.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,919,989.50	357,941.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,077.54	FEE SCHEDULE LAB	2,399,326.71	327,224.25
EKG/ECG	196,248.75	12,338.75	MRI SERVICES	57,220.25	11,376.25
IV THERAPY	356,278.75	46,050.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	670,573.18	146,763.56	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	18,671.50	268.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	32,276.25	5,017.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	275,974.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	18,991.50	16,156.51	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,345,275.25	42,011.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	212,432.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	2,208.25
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	387,049.57	126,453.45
RADIOLOGY THERAPEUTIC	5,601.00	1,831.50	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	554.03	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	290.53	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,026.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,433.00	1,632.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	65,066.75	0.00
LITHOTRIPSY	7,170.50	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	412,762.75	91,779.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	46,555.25	5,325.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	40,324.75	12,990.25			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	102,761.87	216,335.88			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,035.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	66,052.62	3,342.00			
			TOTAL ANCILLARY	11,007,986.70	1,441,876.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,007,986.70	1,441,876.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	313,820.75	ADJUSTMENTS	0.00
COVERED CHARGES	246,491.50	CONTRACTUAL ALLOW	143,145.36
NON-COVERD CHARGES	67,329.25	TOTAL MEDICAID LIAB	103,346.14
		LESS: COB	103,323.60
		LESS: COPAYMENT	22.54
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 89

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,433.25	0.00	OTHER LAB	1,336.50	0.00
MED/SURG SUPPLY	5,592.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,041.75	0.00	OTHER THERAPEUTIC SVC	0.00	1,041.25
CT SCAN	12,328.50	7,955.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	55,903.25	4,766.50
EKG/ECG	3,542.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,104.25	734.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,095.00	12,632.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	268.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	37.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,549.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	12,518.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	53,257.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,553.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,475.50	644.25
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	80.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,811.00	7,208.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,932.25	2,892.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,188.50	262.25			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	16,674.25			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	960.00	0.00			
			TOTAL ANCILLARY	246,491.50	67,329.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	246,491.50	67,329.25

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,289,905.00	ADJUSTMENTS	862.04
COVERED CHARGES	1,198,422.50	CONTRACTUAL ALLOW	1,160,942.73
NON-COVERD CHARGES	91,482.50	TOTAL MEDICAID LIAB	37,479.77
		LESS: COB	0.00
		LESS: COPAYMENT	1,332.04
		REIMBURSEMENT	36,147.73
		TOTAL NUMBER OF CLAIMS	670

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,862.25	0.00	OTHER LAB	13,486.75	0.00
MED/SURG SUPPLY	1,357.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	105,315.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	97,827.25	43,326.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	262,916.50	37,913.50
EKG/ECG	14,822.50	346.25	MRI SERVICES	0.00	0.00
IV THERAPY	40,111.25	2,314.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	845.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,348.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	502,395.25	2,516.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	115,742.50	3,346.50
RADIOLOGY THERAPEUTIC	3,133.50	487.50	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	97.50	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	13,299.00	1,134.75			
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	960.00	0.00			
			TOTAL ANCILLARY	1,198,422.50	91,482.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,198,422.50	91,482.50

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,320.00	ADJUSTMENTS	0.00
COVERED CHARGES	21,322.25	CONTRACTUAL ALLOW	15,219.79
NON-COVERD CHARGES	997.75	TOTAL MEDICAID LIAB	6,102.46
		LESS: COB	6,078.46
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	10

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	310.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	55.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,060.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,723.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,363.75	816.50
EKG/ECG	1,048.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	890.75	133.50	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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,690.00	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	180.00	47.75
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	21,322.25	997.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	21,322.25	997.75

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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Page: 13

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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,033,786.50	ADJUSTMENTS	10,792.20
COVERED CHARGES	1,716,219.00	CONTRACTUAL ALLOW	1,495,856.88
NON-COVERD CHARGES	317,567.50	TOTAL MEDICAID LIAB	220,362.12
		LESS: COB	0.00
		LESS: COPAYMENT	174.00
		REIMBURSEMENT	220,188.12
		TOTAL NUMBER OF CLAIMS	40

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45,494.25	204.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	172,859.50	486.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,266.25	4,061.50	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	27,859.75	7,827.50
EKG/ECG	4,937.50	4,235.00	MRI SERVICES	0.00	0.00
IV THERAPY	11,905.00	444.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	696,409.00	35,095.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	139,985.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	60,549.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	226,090.25	3,155.50
RADIOLOGY THERAPEUTIC	2,766.75	615.75	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	258,377.75	1,050.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,940.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	49,494.00	260,393.25			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,284.00	0.00			
			TOTAL ANCILLARY	1,716,219.00	317,567.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,716,219.00	317,567.50

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:00:06
 Page: 1

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,389,101.38	ADJUSTMENTS	423,728.52
COVERED CHARGES	19,635,635.87	CONTRACTUAL ALLOW	14,592,138.48
NON-COVERD CHARGES	753,465.51	TOTAL MEDICAID LIAB	5,043,497.39
		LESS: COB	38,875.15
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,004,622.24

TOTAL NUMBER OF ADMISSIONS 702

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,808		0	1,086,700.00		427,524.00
ROUTINE NURSERY	306		2	221,124.00		104,827.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,114		2	1,307,824.00		532,351.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	844		0	1,471,574.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	844		0	1,471,574.00		0.00
TOTAL ACCOMODATIONS	2,958		2	2,779,398.00		532,351.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,604,595.26	59,963.10	OTHER LAB	162,194.00	0.00
MED/SURG SUPPLY	480,698.61	6,091.41	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,408,972.00	47,430.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	583,044.00	7,439.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,292,387.00	33,985.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	146,416.00	708.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	183,136.00	8,250.00	MRI SERVICES	221,147.00	0.00
IV THERAPY	412,750.00	3,594.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,524,928.00	148.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	436,158.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,098,481.00	17,762.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	242,521.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	93,773.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	699,830.00	2,812.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	522,136.00	3,579.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	53,728.00	0.00	INJECTABLE DRUGS	310.76	0.00
RADIOLOGY THERAPEUTIC	51,664.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	56,409.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	138,996.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	35,666.00	2,143.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	487,351.64	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	191,938.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	237,740.00	11,340.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	94,449.00	13,338.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	310,124.00	597.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	49,836.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	34,858.60	1,935.00			
			TOTAL ANCILLARY	16,856,237.87	221,114.51
			TOTAL ACCOMODATIONS	2,779,398.00	532,351.00
			TOTAL CHARGES	19,635,635.87	753,465.51

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	147,166.55	ADJUSTMENTS	0.00
COVERED CHARGES	142,222.55	CONTRACTUAL ALLOW	97,759.44
NON-COVERD CHARGES	4,944.00	TOTAL MEDICAID LIAB	44,463.11
		LESS: COB	44,463.11
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 8

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	14		0	8,540.00		4,944.00
ROUTINE NURSERY	0		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	8,540.00		4,944.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	6		0	14,118.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	14,118.00		0.00
TOTAL ACCOMODATIONS	20		0	22,658.00		4,944.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,156.76	0.00	OTHER LAB	1,174.00	0.00
MED/SURG SUPPLY	2,773.79	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	22,917.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	802.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,634.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	454.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	750.00	0.00	MRI SERVICES	4,466.00	0.00
IV THERAPY	538.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,520.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	26,510.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,342.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,521.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,538.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	16,842.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,290.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	187.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,951.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,198.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	119,564.55	0.00
			TOTAL ACCOMODATIONS	22,658.00	4,944.00
			TOTAL CHARGES	142,222.55	4,944.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:00:14
Page: 5

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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,063,291.56	ADJUSTMENTS	613,806.59
COVERED CHARGES	14,636,687.10	CONTRACTUAL ALLOW	11,911,169.42
NON-COVERD CHARGES	2,426,604.46	TOTAL MEDICAID LIAB	2,725,517.68
		LESS: COB	24,109.36
		LESS: COPAYMENT	4,104.00
		REIMBURSEMENT	2,697,304.32
		ALL OTHER	2,516,292.76
		FEE SCHEDULE-LAB	147,440.11
		INJECTABLE DRUGS	33,571.45

TOTAL NUMBER OF CLAIMS 4,734

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	432,180.10	53,205.20	OTHER LAB	130,339.00	1,174.00
MED/SURG SUPPLY	227,640.23	20,644.36	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	174.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	813,876.00	12,945.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,773,979.00	670,530.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	28,588.00	13,981.11	FEE SCHEDULE LAB	2,406,716.80	363,300.80
EKG/ECG	255,071.00	4,500.00	MRI SERVICES	350,564.00	43,303.00
IV THERAPY	48,281.00	4,487.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,023,480.00	242,527.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	123,028.00	2,068.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	75,995.00	34,775.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	230,848.00	2,760.00	AMBULANCE	0.00	0.00
GI SERVICES	96,909.00	4,057.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,599,506.00	139,572.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	432,893.00	1,704.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	406,936.45	352,271.24
RADIOLOGY THERAPEUTIC	199,746.00	1,802.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	3,640.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	28,512.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	38,078.00	14,212.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	23,718.72	45,322.75
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	593,187.00	134,798.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	18,660.00	6,300.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	308,995.00	98,167.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	374,456.00	117,561.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	225,721.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	397,294.80	8,311.00			
			TOTAL ANCILLARY	14,636,687.10	2,426,604.46
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,636,687.10	2,426,604.46

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:00:37
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	347,713.92	ADJUSTMENTS	0.00
COVERED CHARGES	263,086.41	CONTRACTUAL ALLOW	171,899.81
NON-COVERD CHARGES	84,627.51	TOTAL MEDICAID LIAB	91,186.60
		LESS: COB	91,105.60
		LESS: COPAYMENT	81.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	110

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,113.16	320.00	OTHER LAB	1,174.00	0.00
MED/SURG SUPPLY	3,562.87	570.66	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,343.00	432.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,944.00	33,404.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	48,071.00	5,928.00
EKG/ECG	4,500.00	0.00	MRI SERVICES	16,234.00	3,945.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,029.00	7,777.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,024.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	890.00	799.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,850.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,371.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	85,238.00	1,396.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,087.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,782.18	2,214.85
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	374.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	53.40	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,329.00	20,220.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,660.00	4,900.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,237.00	2,347.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,793.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,800.80	0.00			
			TOTAL ANCILLARY	263,086.41	84,627.51
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	263,086.41	84,627.51

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	792,121.59	ADJUSTMENTS	700.22
COVERED CHARGES	698,783.75	CONTRACTUAL ALLOW	664,617.35
NON-COVERD CHARGES	93,337.84	TOTAL MEDICAID LIAB	34,166.40
		LESS: COB	2,784.06
		LESS: COPAYMENT	906.01
		REIMBURSEMENT	30,476.33
		TOTAL NUMBER OF CLAIMS	561

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,551.11	280.00	OTHER LAB	6,161.00	0.00
MED/SURG SUPPLY	7,949.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	65,169.00	462.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,880.00	43,484.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	144,336.00	18,705.00
EKG/ECG	7,500.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	902.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	991.00	182.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	415,560.00	10,423.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,634.24	4,981.84
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	9,603.00	11,213.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,216.00	1,260.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	2,347.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,331.40	0.00			
			TOTAL ANCILLARY	698,783.75	93,337.84
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	698,783.75	93,337.84

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	288.02	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	5,794.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,374.00	290.00
EKG/ECG	375.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,286.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	10.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	14,117.02	300.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,117.02	300.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,654,504.36	ADJUSTMENTS	32,224.37
COVERED CHARGES	1,562,073.75	CONTRACTUAL ALLOW	1,356,379.34
NON-COVERD CHARGES	92,430.61	TOTAL MEDICAID LIAB	205,694.41
		LESS: COB	0.00
		LESS: COPAYMENT	327.00
		REIMBURSEMENT	205,367.41

TOTAL NUMBER OF CLAIMS 39

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,493.14	3,105.00	OTHER LAB	1,174.00	0.00
MED/SURG SUPPLY	41,559.31	8,758.23	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,579.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,680.00	9,625.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	21,289.00	4,017.00
EKG/ECG	2,250.00	375.00	MRI SERVICES	0.00	0.00
IV THERAPY	12,881.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	169,434.00	10,702.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,529.00	364.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,916.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,329.00	666.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	25,560.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,055,150.10	12,655.38
RADIOLOGY THERAPEUTIC	107,672.00	24,266.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	7,128.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	218.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,225.00	7,200.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,792.00	993.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	13,849.00	2,290.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	10,821.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	17,673.20	286.00			
			TOTAL ANCILLARY	1,562,073.75	92,430.61
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,562,073.75	92,430.61

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:00:46
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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:00:54
 Page: 1

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	85,283,394.94	ADJUSTMENTS	3,717,707.10
COVERED CHARGES	81,940,795.93	CONTRACTUAL ALLOW	56,746,085.25
NON-COVERD CHARGES	3,342,599.01	TOTAL MEDICAID LIAB	25,194,710.68
		LESS: COB	198,807.04
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	24,995,903.64

TOTAL NUMBER OF ADMISSIONS 2,201

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	11,989		16	14,285,725.00		1,163,660.00
ROUTINE NURSERY	970		33	1,048,845.00		30,240.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		5,140.00
TOTAL ROUTINE	12,959		49	15,334,570.00		1,199,040.00
SPECIAL CARE SERVICES						
CCU	373		0	1,643,065.00		0.00
ICU	1,722		0	7,582,760.00		8,810.00
NICU	391		0	1,110,440.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,486		0	10,336,265.00		8,810.00
TOTAL ACCOMODATIONS	15,445		49	25,670,835.00		1,207,850.00

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,219,845.20	107,268.78	OTHER LAB	421,468.00	2,555.00
MED/SURG SUPPLY	4,680,490.85	125,357.54	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,299,653.02	164,025.90	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,128,249.00	10,178.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,743,473.00	33,862.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,024,808.07	43,729.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	354,332.00	924.00	MRI SERVICES	1,543,397.00	8,973.00
IV THERAPY	26,630.00	648.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,385,260.00	23,767.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,533,685.00	17,130.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,881,188.00	64,755.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,568,023.00	3,842.00	AMBULANCE	0.00	0.00
GI SERVICES	458,462.00	14,761.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,817,019.00	19,674.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	494,243.00	3,263.00	DRUG-SPECIFIC/HOME IV	0.00	99,567.26
LABORATORY PATHOLOGIC	580,804.00	5,628.00	INJECTABLE DRUGS	7,827,994.21	211,330.53
RADIOLOGY THERAPEUTIC	57,992.00	21,510.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	294,637.38	6,936.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	179,272.46	2,587.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,412,659.00	91,954.00	PATIENT CONVENIENCE	0.00	1,505.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	196.00	6,547.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,297,454.40	136.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	455,362.00
OTHER IMAGING SERVICE	327,458.00	360,013.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,546,931.00	43,735.00			
ONCOLOGY	1,034.34	0.00			
NUCLEAR MEDICINE	117,883.00	126,150.00			
AUDIOLOGY	18,360.00	0.00			
CARDIOLOGY	2,790,870.00	55,944.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	169,423.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	66,766.00	1,131.00			
			TOTAL ANCILLARY	56,269,960.93	2,134,749.01
			TOTAL ACCOMODATIONS	25,670,835.00	1,207,850.00
			TOTAL CHARGES	81,940,795.93	3,342,599.01

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013287004395	09/28/13 - 10/06/13	11/04/13	0.00	6,282.00	0.00	0.00	0.00
614	2013344039500	11/04/13 - 11/16/13	12/16/13	0.00	6,282.00	0.00	0.00	0.00
614	2213346000671	10/04/13 - 10/16/13	12/16/13	0.00	6,282.00	0.00	0.00	0.00
614	2014010044740	12/19/13 - 12/28/13	01/13/14	0.00	6,282.00	0.00	0.00	0.00
614	2014013022379	12/21/13 - 01/02/14	01/20/14	0.00	6,282.00	0.00	0.00	0.00
614	2014016031714	12/25/13 - 01/05/14	02/24/14	0.00	6,282.00	0.00	0.00	0.00
614	2014034023490	01/23/14 - 01/27/14	02/10/14	0.00	6,282.00	0.00	0.00	0.00
614	2014051004613	02/03/14 - 02/13/14	02/24/14	0.00	6,282.00	0.00	0.00	0.00
614	2014057007504	01/05/14 - 01/13/14	03/03/14	0.00	6,282.00	0.00	0.00	0.00
614	2214066002599	01/24/14 - 02/03/14	03/10/14	0.00	6,282.00	0.00	0.00	0.00
614	2014069001463	02/23/14 - 03/03/14	03/17/14	0.00	6,282.00	0.00	0.00	0.00
614	2014092028072	03/04/14 - 03/08/14	04/07/14	0.00	6,282.00	0.00	0.00	0.00
614	2014107025363	10/31/13 - 11/04/13	04/21/14	0.00	2,841.00	0.00	0.00	0.00
614	2014122030311	04/10/14 - 04/22/14	05/05/14	0.00	6,273.00	0.00	0.00	0.00
614	2014132001940	04/16/14 - 05/02/14	05/19/14	0.00	2,350.00	0.00	0.00	0.00
614	2014139002267	04/28/14 - 05/06/14	05/26/14	0.00	6,282.00	0.00	0.00	0.00
614	2014141017615	05/07/14 - 05/13/14	05/26/14	0.00	6,282.00	0.00	0.00	0.00
614	2014141018111	05/06/14 - 05/09/14	05/26/14	0.00	6,282.00	0.00	0.00	0.00
614	2014146000555	05/04/14 - 05/16/14	06/02/14	0.00	2,768.00	0.00	0.00	0.00
614	2014148006159	03/07/14 - 04/04/14	06/02/14	0.00	6,282.00	0.00	0.00	0.00
614	5214150000210	02/02/14 - 03/01/14	06/09/14	0.00	6,282.00	0.00	0.00	0.00
614	2014153002027	05/17/14 - 05/22/14	06/09/14	0.00	5,609.00	0.00	0.00	0.00
615	2014155047849	05/15/14 - 05/22/14	06/09/14	0.00	2,871.00	0.00	0.00	0.00
614	2014160001119	05/21/14 - 05/31/14	06/16/14	0.00	6,282.00	0.00	0.00	0.00
614	2014161012464	05/26/14 - 05/31/14	06/23/14	0.00	12,564.00	0.00	0.00	0.00
615	2214161012963	11/06/13 - 11/08/13	06/16/14	0.00	11,228.00	0.00	0.00	0.00
614	2014162024930	05/16/14 - 05/27/14	06/16/14	0.00	2,768.00	0.00	0.00	0.00
614	2014169016803	06/03/14 - 06/10/14	06/23/14	0.00	2,768.00	0.00	0.00	0.00
615	2014169016837	06/03/14 - 06/10/14	06/23/14	0.00	2,871.00	0.00	0.00	0.00
614	2214176008983	03/18/14 - 04/29/14	06/30/14	0.00	6,282.00	0.00	0.00	0.00
615	2014178022964	06/05/14 - 06/14/14	06/30/14	0.00	14,099.00	0.00	0.00	0.00
614	5214184000154	09/24/13 - 10/22/13	07/07/14	0.00	6,282.00	0.00	0.00	0.00
614	2014185040243	06/24/14 - 06/28/14	07/21/14	0.00	6,282.00	0.00	0.00	0.00
615	2014185040303	06/17/14 - 06/27/14	07/07/14	0.00	8,485.00	0.00	0.00	0.00
615	2014190018374	03/30/14 - 04/05/14	07/14/14	0.00	11,228.00	0.00	0.00	0.00
614	2214191003892	05/08/14 - 06/26/14	07/14/14	0.00	5,536.00	0.00	0.00	0.00
615	2014195001439	06/20/14 - 07/08/14	07/21/14	0.00	11,228.00	0.00	0.00	0.00
614	2014195001562	04/21/14 - 05/01/14	07/21/14	0.00	6,282.00	0.00	0.00	0.00
614	2214196000430	05/18/14 - 06/12/14	07/21/14	0.00	2,768.00	0.00	0.00	0.00
614	2214198004645	05/17/14 - 06/12/14	07/21/14	0.00	2,832.00	0.00	0.00	0.00
614	2014199028123	07/02/14 - 07/09/14	07/21/14	0.00	2,350.00	0.00	0.00	0.00
615	2014205025998	07/10/14 - 07/17/14	07/28/14	0.00	2,871.00	0.00	0.00	0.00

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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CLM#	CLM#	DATE	DATE	DATE	AMOUNT	AMOUNT	AMOUNT	AMOUNT		
614	2014209003146	07/08/14	-	07/15/14	08/04/14	0.00	2,768.00	0.00	0.00	0.00
614	2014209003180	06/25/14	-	07/07/14	08/04/14	0.00	2,832.00	0.00	0.00	0.00
614	2014209003192	07/16/14	-	07/19/14	08/04/14	0.00	5,609.00	0.00	0.00	0.00
614	2014211020153	04/19/14	-	05/08/14	08/04/14	0.00	6,282.00	0.00	0.00	0.00
614	2014213027368	06/18/14	-	07/03/14	08/04/14	0.00	5,600.00	0.00	0.00	0.00
615	2014223003442	07/29/14	-	08/05/14	08/18/14	0.00	11,228.00	0.00	0.00	0.00
615	2014230004057	07/29/14	-	08/06/14	08/25/14	0.00	2,871.00	0.00	0.00	0.00
614	2014235028782	08/09/14	-	08/15/14	09/01/14	0.00	12,564.00	0.00	0.00	0.00
618	2014235028858	07/25/14	-	08/01/14	09/01/14	0.00	2,768.00	0.00	0.00	0.00
614	2014238009196	08/13/14	-	08/19/14	09/01/14	0.00	6,282.00	0.00	0.00	0.00
614	2014242027193	08/01/14	-	08/12/14	09/08/14	0.00	12,564.00	0.00	0.00	0.00
614	5214253000137	05/05/14	-	07/08/14	09/15/14	0.00	2,832.00	0.00	0.00	0.00
614	2014255009092	08/11/14	-	08/22/14	09/15/14	0.00	6,282.00	0.00	0.00	0.00
614	2014260029086	07/31/14	-	08/11/14	09/22/14	0.00	12,564.00	0.00	0.00	0.00
614	2014261029342	08/29/14	-	09/08/14	09/22/14	0.00	6,597.00	0.00	0.00	0.00
614	2014267031151	08/28/14	-	09/04/14	09/29/14	0.00	13,194.00	0.00	0.00	0.00
614	2214268006801	07/05/14	-	09/12/14	09/29/14	0.00	2,841.00	0.00	0.00	0.00
614	2214279000850	07/25/14	-	08/07/14	10/13/14	0.00	5,664.00	0.00	0.00	0.00
615	2014282024322	02/23/14	-	03/04/14	10/13/14	0.00	11,228.00	0.00	0.00	0.00
615	9114303004204	07/23/14	-	07/24/14	11/10/14	0.00	2,871.00	0.00	938.64	0.00
614	5214311000149	08/28/14	-	10/02/14	11/17/14	0.00	9,494.00	0.00	0.00	0.00
614	2014365029445	02/15/14	-	02/23/14	01/05/15	0.00	2,350.00	0.00	0.00	0.00
614	2015016010368	10/04/13	-	10/09/13	01/19/15	0.00	2,768.00	0.00	0.00	0.00
614	2215023021722	08/01/14	-	08/12/14	01/26/15	0.00	2,350.00	0.00	0.00	0.00
614	2215030021819	03/01/14	-	03/05/14	02/02/15	0.00	2,350.00	0.00	0.00	0.00
614	5215071000044	04/09/14	-	08/31/14	03/16/15	0.00	2,841.00	0.00	0.00	0.00
614	2215098013225	06/18/14	-	07/09/14	04/13/15	0.00	2,350.00	0.00	0.00	0.00
615	2215098013225	06/18/14	-	07/09/14	04/13/15	0.00	11,228.00	0.00	0.00	0.00
614	2215104013656	02/11/14	-	02/14/14	04/20/15	0.00	12,564.00	0.00	0.00	0.00
615	2215110012179	08/28/14	-	09/13/14	04/27/15	0.00	11,228.00	0.00	0.00	0.00
615	2215141016211	08/28/14	-	09/17/14	05/25/15	0.00	5,886.00	0.00	0.00	0.00

TOTAL 0.00 455,362.00 0.00 938.64 0.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:01:06
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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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,136,585.05	ADJUSTMENTS	0.00
COVERED CHARGES	1,119,470.05	CONTRACTUAL ALLOW	507,662.10
NON-COVERD CHARGES	17,115.00	TOTAL MEDICAID LIAB	611,807.95
		LESS: COB	611,807.95
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 47

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	165		0	202,125.00		10,290.00
ROUTINE NURSERY	11		0	14,220.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	176		0	216,345.00		10,290.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	10		0	44,050.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	44,050.00		0.00
TOTAL ACCOMODATIONS	186		0	260,395.00		10,290.00

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,637.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	61,055.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	83,386.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,504.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	26,252.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,447.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,799.00	0.00	MRI SERVICES	17,369.00	0.00
IV THERAPY	233.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	146,216.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	206,794.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,498.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	57,388.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,612.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	17,270.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,548.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	13,542.00	0.00	INJECTABLE DRUGS	68,403.40	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,307.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,847.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	20,969.40	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	6,282.00
OTHER IMAGING SERVICE	3,281.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	52,719.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,600.00	543.00			
AUDIOLOGY	124.00	0.00			
CARDIOLOGY	1,108.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	166.00	0.00			
			TOTAL ANCILLARY	859,075.05	6,825.00
			TOTAL ACCOMODATIONS	260,395.00	10,290.00
			TOTAL CHARGES	1,119,470.05	17,115.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:01:06
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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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014154020789	04/17/14 - 04/29/14	06/09/14	0.00	6,282.00	0.00	9,562.30	0.00
TOTAL				0.00	6,282.00	0.00	9,562.30	0.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:01:09
Page: 8

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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	33,052,919.54	ADJUSTMENTS	1,070,321.39
COVERED CHARGES	24,867,178.27	CONTRACTUAL ALLOW	19,036,595.96
NON-COVERD CHARGES	8,185,741.27	TOTAL MEDICAID LIAB	5,830,582.31
		LESS: COB	13,305.55
		LESS: COPAYMENT	18,844.69
		REIMBURSEMENT	5,798,432.07
		ALL OTHER	3,915,226.44
		FEE SCHEDULE-LAB	518,713.61
		INJECTABLE DRUGS	1,364,492.02

TOTAL NUMBER OF CLAIMS 9,819

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	212,904.58	371,043.34	OTHER LAB	313,161.00	196.00
MED/SURG SUPPLY	621,367.50	331,942.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	494.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	845,569.00	79,158.00	OTHER THERAPEUTIC SVC	0.00	12,847.00
CT SCAN	1,875,142.00	987,699.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,846.00	20,023.02	FEE SCHEDULE LAB	4,423,774.94	688,296.50
EKG/ECG	281,072.00	2,751.00	MRI SERVICES	1,508,093.00	335,705.00
IV THERAPY	1,278,525.00	40,856.20	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,993,103.00	623,983.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	78,248.00	128.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	134,339.00	42,926.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	522,821.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	85,656.00	64,881.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,617,818.00	110,767.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	504,111.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	588.00	INJECTABLE DRUGS	2,992,058.47	1,702,700.18
RADIOLOGY THERAPEUTIC	277,276.00	8,074.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	6,933.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	5,142.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	303,706.00	PATIENT CONVENIENCE	0.00	10.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	84,274.00	10,161.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	23,660.40	336,586.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	222,740.00
OTHER IMAGING SERVICE	1,000,676.00	839,497.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	379,774.50	56,742.00			
ONCOLOGY	0.00	1,495.00			
NUCLEAR MEDICINE	498,770.00	358,643.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	851,503.00	540,231.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,316.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	450,318.88	77,512.00			
			TOTAL ANCILLARY	24,867,178.27	8,184,456.27
			TOTAL ACCOMODATIONS	0.00	1,285.00
			TOTAL CHARGES	24,867,178.27	8,185,741.27

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013287004641	10/08/13 - 10/08/13	10/21/13	0.00	6,282.00	0.00	0.00	0.00
614	2013304049632	10/22/13 - 10/22/13	11/04/13	0.00	6,282.00	0.00	0.00	0.00
614	2013308014291	10/28/13 - 10/28/13	11/11/13	0.00	6,282.00	0.00	0.00	0.00
614	2013322018589	11/08/13 - 11/08/13	11/25/13	0.00	6,282.00	0.00	0.00	0.00
614	2013331070302	11/19/13 - 11/19/13	12/02/13	0.00	6,282.00	0.00	0.00	0.00
614	2013344040786	11/15/13 - 11/15/13	12/16/13	0.00	6,282.00	0.00	0.00	0.00
614	5214095008967	01/21/14 - 01/21/14	06/02/14	0.00	6,282.00	0.00	0.00	0.00
614	2014107025460	04/08/14 - 04/08/14	04/21/14	0.00	2,841.00	0.00	0.00	0.00
614	2014122030389	04/24/14 - 04/24/14	05/05/14	0.00	6,282.00	0.00	0.00	0.00
614	2014125002565	04/28/14 - 04/28/14	05/12/14	0.00	6,282.00	0.00	0.00	0.00
614	2014125002485	04/23/14 - 04/23/14	05/12/14	0.00	6,282.00	0.00	0.00	0.00
614	2014129045771	04/21/14 - 04/21/14	05/12/14	0.00	6,282.00	0.00	0.00	0.00
615	2014140011682	04/22/14 - 04/22/14	05/26/14	0.00	5,614.00	0.00	0.00	0.00
614	2014162072773	05/28/14 - 05/28/14	06/16/14	0.00	2,768.00	0.00	0.00	0.00
614	2014164021415	06/04/14 - 06/04/14	06/16/14	0.00	6,282.00	0.00	0.00	0.00
614	2014175020452	06/13/14 - 06/13/14	06/30/14	0.00	1,500.00	0.00	0.00	0.00
614	2014175020452	06/13/14 - 06/13/14	06/30/14	0.00	215.00	0.00	0.00	0.00
618	2014175020452	06/13/14 - 06/13/14	06/30/14	0.00	2,768.00	0.00	0.00	0.00
615	2014175020713	06/12/14 - 06/12/14	06/30/14	0.00	5,614.00	0.00	0.00	0.00
615	2014175020713	06/12/14 - 06/12/14	06/30/14	0.00	5,614.00	0.00	0.00	0.00
615	2014190018598	06/30/14 - 06/30/14	07/14/14	0.00	5,614.00	0.00	0.00	0.00
615	2014190018598	06/30/14 - 06/30/14	07/14/14	0.00	5,614.00	0.00	0.00	0.00
615	2214211009750	06/22/14 - 06/22/14	08/04/14	0.00	5,614.00	0.00	0.00	0.00
615	2214211009750	06/22/14 - 06/22/14	08/04/14	0.00	5,614.00	0.00	0.00	0.00
614	2014220008061	02/20/14 - 02/20/14	08/11/14	0.00	5,434.00	0.00	0.00	0.00
614	2014220008079	08/01/14 - 08/01/14	08/11/14	0.00	2,768.00	0.00	0.00	0.00
614	2014224021588	08/04/14 - 08/04/14	08/18/14	0.00	6,282.00	0.00	0.00	0.00
614	2014224021727	08/01/14 - 08/01/14	08/18/14	0.00	2,768.00	0.00	0.00	0.00
614	2014226001207	08/06/14 - 08/06/14	08/18/14	0.00	6,282.00	0.00	0.00	0.00
614	2014226001207	08/06/14 - 08/06/14	08/18/14	0.00	6,282.00	0.00	0.00	0.00
615	2014227022688	08/04/14 - 08/04/14	08/18/14	0.00	5,614.00	0.00	0.00	0.00
615	2014227022688	08/04/14 - 08/04/14	08/18/14	0.00	5,614.00	0.00	0.00	0.00
615	2014232068509	08/06/14 - 08/06/14	08/25/14	0.00	5,614.00	0.00	0.00	0.00
615	2014232068509	08/06/14 - 08/06/14	08/25/14	0.00	5,614.00	0.00	0.00	0.00
614	2014232068787	08/09/14 - 08/09/14	08/25/14	0.00	6,282.00	0.00	0.00	0.00
618	2014238009712	08/14/14 - 08/14/14	09/01/14	0.00	2,768.00	0.00	0.00	0.00
615	2014241028188	08/18/14 - 08/18/14	09/01/14	0.00	2,871.00	0.00	0.00	0.00
615	2014241028188	08/18/14 - 08/18/14	09/01/14	0.00	2,871.00	0.00	0.00	0.00
615	2014248022968	08/15/14 - 08/15/14	09/08/14	0.00	5,614.00	0.00	0.00	0.00
615	2014248022968	08/15/14 - 08/15/14	09/08/14	0.00	5,614.00	0.00	0.00	0.00
615	2014254027364	08/29/14 - 08/29/14	09/15/14	0.00	5,614.00	0.00	0.00	0.00
614	2015012015396	06/04/14 - 06/04/14	01/19/15	0.00	2,832.00	0.00	262.09	0.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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EMORY UNIVERSITY HOSPITAL MIDTOWN		PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00		
550 PEACHTREE ST NE		000000503A	SERVICE DATES	09/01/13	THROUGH	08/31/14		
ATLANTA,GA 30308-2247			ADMISSION DATES	00/00/00	THROUGH	00/00/00		
615	2015099024009	01/28/14 - 01/28/14	04/13/15	0.00	5,614.00	0.00	0.00	0.00
615	2015099024009	01/28/14 - 01/28/14	04/13/15	0.00	5,614.00	0.00	0.00	0.00
TOTAL				0.00	222,740.00	0.00	262.09	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	748,504.23	ADJUSTMENTS	0.00
COVERED CHARGES	444,241.98	CONTRACTUAL ALLOW	160,933.35
NON-COVERD CHARGES	304,262.25	TOTAL MEDICAID LIAB	283,308.63
		LESS: COB	282,806.53
		LESS: COPAYMENT	502.10
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 198

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIVERSITY HOSPITAL MIDTOWN PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
 550 PEACHTREE ST NE 000000503A SERVICE DATES 09/01/13 THROUGH 08/31/14
 ATLANTA,GA 30308-2247 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,693.95	7,904.95	OTHER LAB	747.00	0.00
MED/SURG SUPPLY	20,713.00	5,709.98	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,379.00	498.00	OTHER THERAPEUTIC SVC	0.00	4,340.00
CT SCAN	19,517.00	20,231.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,432.00	353.00	FEE SCHEDULE LAB	104,676.00	18,528.00
EKG/ECG	3,537.00	0.00	MRI SERVICES	26,561.00	33,173.00
IV THERAPY	17,266.00	83.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	56,158.00	55,415.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,896.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	518.00	25,141.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	24,123.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,430.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	42,742.00	1,444.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,833.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,610.03	62,413.32
RADIOLOGY THERAPEUTIC	8,380.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,462.00	127.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	722.00	72.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	30,074.00
OTHER IMAGING SERVICE	2,736.00	23,992.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	35,814.00	1,001.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,525.00	2,217.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,432.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,339.00	11,545.00			
			TOTAL ANCILLARY	444,241.98	304,262.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	444,241.98	304,262.25

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014174001441	06/04/14 - 06/04/14	06/30/14	0.00	6,282.00	0.00	3,938.85	0.00
615	2014240027350	08/19/14 - 08/19/14	09/01/14	0.00	5,614.00	0.00	0.00	0.00
615	2014240027350	08/19/14 - 08/19/14	09/01/14	0.00	5,614.00	0.00	0.00	0.00
614	2215139007866	08/01/14 - 08/01/14	05/25/15	0.00	6,282.00	0.00	8,661.98	0.00
614	2215139007866	08/01/14 - 08/01/14	05/25/15	0.00	6,282.00	0.00	8,661.98	0.00
TOTAL				0.00	30,074.00	0.00	21,262.81	0.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	821,578.65	ADJUSTMENTS	1,055.80
COVERED CHARGES	734,834.86	CONTRACTUAL ALLOW	687,957.10
NON-COVERD CHARGES	86,743.79	TOTAL MEDICAID LIAB	46,877.76
		LESS: COB	0.00
		LESS: COPAYMENT	2,325.05
		REIMBURSEMENT	44,552.71
		TOTAL NUMBER OF CLAIMS	842

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,650.80	7,636.27	OTHER LAB	17,986.00	0.00
MED/SURG SUPPLY	3,016.00	694.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	51,499.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	51,915.00	33,359.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	134,863.00	23,086.00
EKG/ECG	13,755.00	0.00	MRI SERVICES	18,423.00	3,073.00
IV THERAPY	803.00	263.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,572.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	376.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,981.00	116.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	406,935.00	4,015.00	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	10,091.56	4,936.02
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	40.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,851.00	7,101.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,300.00	209.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	985.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,817.50	1,230.50			
			TOTAL ANCILLARY	734,834.86	86,743.79
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	734,834.86	86,743.79

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,546.52	ADJUSTMENTS	0.00
COVERED CHARGES	7,680.52	CONTRACTUAL ALLOW	4,099.26
NON-COVERD CHARGES	866.00	TOTAL MEDICAID LIAB	3,581.26
		LESS: COB	3,578.26
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.28	35.00	OTHER LAB	2,780.00	0.00
MED/SURG SUPPLY	24.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,113.00	596.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,747.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16.24	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	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	235.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,680.52	866.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,680.52	866.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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Page: 19

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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,461,676.60	ADJUSTMENTS	223,175.63
COVERED CHARGES	2,238,096.54	CONTRACTUAL ALLOW	1,558,775.97
NON-COVERD CHARGES	223,580.06	TOTAL MEDICAID LIAB	679,320.57
		LESS: COB	0.00
		LESS: COPAYMENT	1,085.02
		REIMBURSEMENT	678,235.55
		TOTAL NUMBER OF CLAIMS	121

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,571.33	4,359.03	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	64,698.76	6,319.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,934.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,446.00	1,560.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	858.00	FEE SCHEDULE LAB	125,430.00	17,236.80
EKG/ECG	1,310.00	0.00	MRI SERVICES	41,933.00	0.00
IV THERAPY	163,605.00	1,258.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	192,894.00	36,630.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,932.00	236.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	46,512.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	72,994.00	218.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	23,613.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,198,030.45	100,994.23
RADIOLOGY THERAPEUTIC	71,131.00	2,315.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	569.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	452.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	394.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	108,873.00	7,360.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	776.00	5,487.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	23,252.00	3,670.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,141.00	2,016.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	38,514.00	31,570.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,506.00	78.00			
			TOTAL ANCILLARY	2,238,096.54	223,580.06
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,238,096.54	223,580.06

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

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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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	99,625.32	ADJUSTMENTS	0.00
COVERED CHARGES	98,746.05	CONTRACTUAL ALLOW	27,144.40
NON-COVERD CHARGES	879.27	TOTAL MEDICAID LIAB	71,601.65
		LESS: COB	71,568.65
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

Report : CLM-0814-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	575.00	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	1,431.00	552.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,411.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	84,457.05	184.27
RADIOLOGY THERAPEUTIC	4,972.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	900.00	143.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	98,746.05	879.27
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	98,746.05	879.27

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:02:12
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,665,916.31	ADJUSTMENTS	176,225.92
COVERED CHARGES	5,578,866.56	CONTRACTUAL ALLOW	2,968,837.44
NON-COVERD CHARGES	87,049.75	TOTAL MEDICAID LIAB	2,610,029.12
		LESS: COB	19,816.35
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,590,212.77

TOTAL NUMBER OF ADMISSIONS 326

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,125		0	740,420.00		18,341.00
ROUTINE NURSERY	29		0	19,140.00		8,979.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		3.00
TOTAL ROUTINE	1,154		0	759,560.00		27,323.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	418		0	590,330.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	418		0	590,330.00		0.00
TOTAL ACCOMODATIONS	1,572		0	1,349,890.00		27,323.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	373,761.74	0.00	OTHER LAB	17,698.00	0.00
MED/SURG SUPPLY	425,944.14	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	939,835.87	27.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	114,173.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	369,642.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	38,265.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	42,114.00	0.00	MRI SERVICES	32,640.00	0.00
IV THERAPY	48,059.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	405,356.14	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	25,779.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	134,639.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	96,818.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	137,009.50	0.00	SPECIAL SERVICES	0.00	19,545.00
RECOVERY ROOM	53,036.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	10,016.00	0.00	INJECTABLE DRUGS	633,842.94	0.00
RADIOLOGY THERAPEUTIC	522.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	9,590.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,976.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	21,760.00	544.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	218.00	8,634.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	103,550.23	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	3,091.00
OTHER IMAGING SERVICE	24,207.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	61,328.00	24,128.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	11,681.00	3,757.00			
AUDIOLOGY	2,254.00	0.00			
CARDIOLOGY	82,539.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,353.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,369.00	0.00			
			TOTAL ANCILLARY	4,228,976.56	59,726.75
			TOTAL ACCOMODATIONS	1,349,890.00	27,323.00
			TOTAL CHARGES	5,578,866.56	87,049.75

Report : CLM-0800-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:02:12
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014076027651	11/09/13 - 11/22/13	03/24/14	0.00	3,091.00	0.00	0.00	0.00
TOTAL				0.00	3,091.00	0.00	0.00	0.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:02:15
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,760,665.39	ADJUSTMENTS	282,759.58
COVERED CHARGES	5,494,273.90	CONTRACTUAL ALLOW	4,157,801.53
NON-COVERD CHARGES	1,266,391.49	TOTAL MEDICAID LIAB	1,336,472.37
		LESS: COB	110.58
		LESS: COPAYMENT	4,446.00
		REIMBURSEMENT	1,331,915.79
		ALL OTHER	901,147.77
		FEE SCHEDULE-LAB	164,234.81
		INJECTABLE DRUGS	266,533.21
		TOTAL NUMBER OF CLAIMS	4,551

Report : CLM-0804-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:02:15
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,469.96	35,807.87	OTHER LAB	176,996.00	979.00
MED/SURG SUPPLY	164,406.72	8,404.87	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	271,141.00	6,652.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	776,763.00	187,740.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	17,860.00	7,671.00	FEE SCHEDULE LAB	1,345,892.50	573,832.30
EKG/ECG	57,370.00	2,784.00	MRI SERVICES	244,067.00	16,057.00
IV THERAPY	60,600.00	19,574.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	451,104.55	61,863.20	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,477.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,880.00	1,344.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	63,708.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	475,773.00	42,804.00	SPECIAL SERVICES	0.00	300.00
RECOVERY ROOM	62,308.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	587,276.13	223,514.70
RADIOLOGY THERAPEUTIC	36,800.00	3,219.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	706.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	705.00	1,061.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	544.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	114,115.91	12,003.12	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	8,830.13	5,252.43
LITHOTRIPSY	10,761.00	0.00	NO CC/INVALID REV CODE	0.00	2,256.00
OTHER IMAGING SERVICE	151,028.00	13,460.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	12,240.00	4,901.00			
ONCOLOGY	276.00	276.00			
NUCLEAR MEDICINE	150,918.00	20,738.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	95,734.00	12,114.00			
AMBULATORY SURGERY	611.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,832.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	108,330.00	533.00			
			TOTAL ANCILLARY	5,494,273.90	1,266,391.49
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,494,273.90	1,266,391.49

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:02:15
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013345063183	11/20/13 - 11/20/13	12/16/13	0.00	2,256.00	0.00	0.00	0.00
TOTAL				0.00	2,256.00	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:02:32
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	129,596.76	ADJUSTMENTS	0.00
COVERED CHARGES	72,034.51	CONTRACTUAL ALLOW	12,641.23
NON-COVERD CHARGES	57,562.25	TOTAL MEDICAID LIAB	59,393.28
		LESS: COB	59,357.91
		LESS: COPAYMENT	35.37
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 90

Report : CLM-0806-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	535.14	419.52	OTHER LAB	3,395.00	0.00
MED/SURG SUPPLY	1,709.44	132.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,411.00	360.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,282.00	12,164.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	160.00	4,160.00	FEE SCHEDULE LAB	25,798.00	8,087.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	3,184.00
IV THERAPY	676.00	665.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,913.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	42.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	620.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,321.00	1,061.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	553.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,876.93	27,163.40
RADIOLOGY THERAPEUTIC	1,406.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,486.00	166.33	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	701.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,762.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,346.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,041.00	0.00			
			TOTAL ANCILLARY	72,034.51	57,562.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	72,034.51	57,562.25

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	264,710.64	ADJUSTMENTS	373.58
COVERED CHARGES	209,553.27	CONTRACTUAL ALLOW	191,037.13
NON-COVERD CHARGES	55,157.37	TOTAL MEDICAID LIAB	18,516.14
		LESS: COB	38.66
		LESS: COPAYMENT	606.01
		REIMBURSEMENT	17,871.47
		TOTAL NUMBER OF CLAIMS	331

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	271.12	487.25	OTHER LAB	1,160.00	0.00
MED/SURG SUPPLY	2,092.00	330.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,627.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,639.00	12,337.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	72,487.00	36,146.00
EKG/ECG	3,591.00	266.00	MRI SERVICES	0.00	2,256.00
IV THERAPY	4,677.00	338.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	462.00	42.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	81,252.00	2,523.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,671.15	432.12
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	103.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	636.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,663.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,222.00	0.00			
			TOTAL ANCILLARY	209,553.27	55,157.37
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	209,553.27	55,157.37

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,191.23	ADJUSTMENTS	0.00
COVERED CHARGES	3,450.93	CONTRACTUAL ALLOW	1,543.94
NON-COVERD CHARGES	740.30	TOTAL MEDICAID LIAB	1,906.99
		LESS: COB	1,900.99
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	6

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	62.07	14.15	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	174.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,789.00	712.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,402.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4.86	14.15
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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,450.93	740.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,450.93	740.30

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	63,110.92	ADJUSTMENTS	0.00
COVERED CHARGES	61,577.57	CONTRACTUAL ALLOW	36,663.35
NON-COVERD CHARGES	1,533.35	TOTAL MEDICAID LIAB	24,914.22
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	24,899.22
		TOTAL NUMBER OF CLAIMS	5

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	128.26	198.48	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	673.00	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	1,485.00	313.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	38.00	338.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	57,018.31	391.87
RADIOLOGY THERAPEUTIC	2,235.00	200.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	92.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	61,577.57	1,533.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	61,577.57	1,533.35

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

DECATUR HLTH RESOURCES INCHOSP
 450 N CANDLER ST
 DECATUR,GA 30030-2626

PROVIDER NUMBER 000000525A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,650,940.31	ADJUSTMENTS	60,447.05
COVERED CHARGES	2,331,122.32	CONTRACTUAL ALLOW	1,504,473.46
NON-COVERD CHARGES	319,817.99	TOTAL MEDICAID LIAB	826,648.86
		LESS: COB	1,821.37
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	824,827.49

TOTAL NUMBER OF ADMISSIONS 19

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	342		0	232,560.00		313,735.68
ROUTINE NURSERY	3		0	1,632.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	345		0	234,192.00		313,735.68
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	159		0	295,914.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	159		0	295,914.00		0.00
TOTAL ACCOMODATIONS	504		0	530,106.00		313,735.68

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:02:45
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

DECATUR HLTH RESOURCES INCHOSP
 450 N CANDLER ST
 DECATUR,GA 30030-2626

PROVIDER NUMBER
 000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	216,023.90	0.00	OTHER LAB	2,581.75	0.00
MED/SURG SUPPLY	79,786.57	3,006.32	RECREATIONAL THERAPY	222.18	0.00
LABORATORY-GENERAL	191,473.21	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,738.63	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,544.39	2,573.99	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	38,406.83	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,626.76	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	36,844.43	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	896,055.30	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,008.16	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	3,629.64	0.00	INJECTABLE DRUGS	212,022.60	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	24,436.73	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	30,421.08	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	4,905.00	0.00	PATIENT CONVENIENCE	0.00	502.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	782.63	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	817.65	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	13,277.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	115.06	0.00			
CARDIOLOGY	3,726.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,044.58	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,526.24	0.00			
			TOTAL ANCILLARY	1,801,016.32	6,082.31
			TOTAL ACCOMODATIONS	530,106.00	313,735.68
			TOTAL CHARGES	2,331,122.32	319,817.99

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

DECATUR HLTH RESOURCES INCHOSP
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
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SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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DECATUR HLTH RESOURCES INCHOSP
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DECATUR HLTH RESOURCES INCHOSP
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

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DECATUR HLTH RESOURCES INCHOSP
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DECATUR HLTH RESOURCES INCHOSP
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DECATUR HLTH RESOURCES INCHOSP
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DECATUR HLTH RESOURCES INCHOSP
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF 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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	55,840,852.16	ADJUSTMENTS	2,178,061.13
COVERED CHARGES	54,475,432.06	CONTRACTUAL ALLOW	34,452,475.76
NON-COVERD CHARGES	1,365,420.10	TOTAL MEDICAID LIAB	20,022,956.30
		LESS: COB	103,136.37
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	19,919,819.93

TOTAL NUMBER OF ADMISSIONS 3,423

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	9,240		1	6,985,596.00		647,496.96
ROUTINE NURSERY	3,288		17	3,082,814.30		103,310.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	12,528		18	10,068,410.30		750,806.96
SPECIAL CARE SERVICES						
CCU	11		0	9,724.00		0.00
ICU	2,514		0	4,031,551.00		0.00
NICU	447		0	986,082.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		197	0.00		176,868.96
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,972		197	5,027,357.00		176,868.96
TOTAL ACCOMODATIONS	15,500		215	15,095,767.30		927,675.92

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,883,795.88	20,071.00	OTHER LAB	673,947.19	0.00
MED/SURG SUPPLY	1,401,575.50	18,277.05	RECREATIONAL THERAPY	4,943.06	0.00
LABORATORY-GENERAL	7,358,222.40	45,459.84	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,035,485.10	0.00	OTHER THERAPEUTIC SVC	0.00	10,523.80
CT SCAN	1,632,882.47	81,945.70	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	519,432.70	7,420.48	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	413,039.00	0.00	MRI SERVICES	334,510.00	0.00
IV THERAPY	534,014.61	15,452.94	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,273,111.55	28,597.64	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,405,650.28	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,422,927.70	32,402.08	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	603,758.34	0.00	AMBULANCE	0.00	0.00
GI SERVICES	169,637.94	1,110.52	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,764,172.70	2,069.32	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	985,335.62	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,115.10
LABORATORY PATHOLOGIC	343,168.92	0.00	INJECTABLE DRUGS	5,106,255.20	9,804.80
RADIOLOGY THERAPEUTIC	225,202.36	2,523.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	276,514.33	602.08	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	226,333.20	3,090.27	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	241,348.00	3,937.86	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	154.74	1,225.44	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	86,967.09	0.00	IMPL DEV CHARGE PATIENTS	964,710.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	592,665.53	4,862.00			
BLOOD	2,199.39	0.00			
BLOOD STORAGE & PRO.	550,032.84	54,648.16			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	338,954.11	85,881.46			
AUDIOLOGY	147,253.25	0.00			
CARDIOLOGY	1,404,000.96	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	80,271.14	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	377,190.91	6,723.64			
			TOTAL ANCILLARY	39,379,664.76	437,744.18
			TOTAL ACCOMODATIONS	15,095,767.30	927,675.92
			TOTAL CHARGES	54,475,432.06	1,365,420.10

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	827,578.40	ADJUSTMENTS	0.00
COVERED CHARGES	823,862.38	CONTRACTUAL ALLOW	381,078.00
NON-COVERD CHARGES	3,716.02	TOTAL MEDICAID LIAB	442,784.38
		LESS: COB	442,784.38
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 36

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	107		0	82,283.00		0.00
ROUTINE NURSERY	57		0	82,282.18		2,013.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	164		0	164,565.18		2,013.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	13		0	17,711.00		0.00
NICU	22		0	51,443.92		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	35		0	69,154.92		0.00
TOTAL ACCOMODATIONS	199		0	233,720.10		2,013.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	54,022.70	0.00	OTHER LAB	9,241.92	0.00
MED/SURG SUPPLY	28,109.74	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	68,384.14	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,656.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,380.78	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	13,567.60	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,471.16	0.00	MRI SERVICES	1,497.00	0.00
IV THERAPY	1,003.69	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	29,421.43	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	37,144.96	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	81,822.84	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,660.64	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,691.90	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	26,966.68	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,300.62	0.00	INJECTABLE DRUGS	75,053.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	218.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,480.21	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	48,800.30	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,940.91	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	1,357.84			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,068.00	345.18			
AUDIOLOGY	3,195.81	0.00			
CARDIOLOGY	53,593.12	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,044.58	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,403.80	0.00			
			TOTAL ANCILLARY	590,142.28	1,703.02
			TOTAL ACCOMODATIONS	233,720.10	2,013.00
			TOTAL CHARGES	823,862.38	3,716.02

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,561,782.57	ADJUSTMENTS	761,159.12
COVERED CHARGES	19,918,726.49	CONTRACTUAL ALLOW	15,782,439.60
NON-COVERD CHARGES	2,643,056.08	TOTAL MEDICAID LIAB	4,136,286.89
		LESS: COB	7,485.50
		LESS: COPAYMENT	8,087.77
		REIMBURSEMENT	4,120,713.62
		ALL OTHER	3,656,908.91
		FEE SCHEDULE-LAB	312,646.14
		INJECTABLE DRUGS	151,158.57
		TOTAL NUMBER OF CLAIMS	7,998

Report : CLM-0804-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	310,473.24	5,046.40	OTHER LAB	605,297.08	9,021.18
MED/SURG SUPPLY	423,065.23	48,682.26	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	119.03	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	972,406.09	15,185.07	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,525,232.68	173,915.57	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	34,987.98	38,709.76	FEE SCHEDULE LAB	3,511,764.27	715,506.75
EKG/ECG	373,712.76	8,520.12	MRI SERVICES	385,254.00	23,030.60
IV THERAPY	801,227.87	66,411.33	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,477,110.15	346,447.63	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	120,119.04	703.80	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	134,329.12	29,934.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	419,662.63	0.00	AMBULANCE	0.00	0.00
GI SERVICES	58,549.28	21,139.71	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,848,412.07	6,886.93	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	641,107.04	2,539.38	DRUG-SPECIFIC/HOME IV	0.00	5,695.20
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	806,098.80	214,969.04
RADIOLOGY THERAPEUTIC	297,333.60	14,670.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,219.98	11,315.85	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,779.90	10,851.86	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	42,901.76	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	45,612.44	1,948.14	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	407.34	0.00	IMPL DEV CHARGE PATIENTS	59,107.09	379,023.53
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,531,884.88	180,108.29			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	80,735.00	46,496.52			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	268,767.59	135,715.97			
AUDIOLOGY	6,012.13	941.63			
CARDIOLOGY	404,173.43	76,040.38			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	27,198.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	742,685.28	10,578.39			
			TOTAL ANCILLARY	19,918,726.49	2,643,056.08
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	19,918,726.49	2,643,056.08

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	560,051.40	ADJUSTMENTS	0.00
COVERED CHARGES	363,325.01	CONTRACTUAL ALLOW	139,381.58
NON-COVERD CHARGES	196,726.39	TOTAL MEDICAID LIAB	223,943.43
		LESS: COB	223,850.43
		LESS: COPAYMENT	93.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 146

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,672.80	0.00	OTHER LAB	19,149.28	1,155.24
MED/SURG SUPPLY	6,163.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,321.48	3,780.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,921.91	15,965.56	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	60,103.46	14,768.37
EKG/ECG	4,417.84	0.00	MRI SERVICES	8,954.00	259.90
IV THERAPY	35,098.16	1,635.95	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	28,136.47	9,508.69	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,185.10	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	541.44	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,807.82	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	72,031.45	531.66	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	15,466.21	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,993.40	16,822.00
RADIOLOGY THERAPEUTIC	794.00	14,433.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	281.06	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,361.00	92,435.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	28,037.75	20,545.70			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,399.02	4,885.32			
AUDIOLOGY	210.28	0.00			
CARDIOLOGY	3,338.81	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,938.52	0.00			
			TOTAL ANCILLARY	363,325.01	196,726.39
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	363,325.01	196,726.39

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,153,933.55	ADJUSTMENTS	1,973.77
COVERED CHARGES	1,073,860.08	CONTRACTUAL ALLOW	1,025,919.53
NON-COVERD CHARGES	80,073.47	TOTAL MEDICAID LIAB	47,940.55
		LESS: COB	0.00
		LESS: COPAYMENT	1,755.05
		REIMBURSEMENT	46,185.50
		TOTAL NUMBER OF CLAIMS	857

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,528.90	0.00	OTHER LAB	9,000.54	0.00
MED/SURG SUPPLY	6,877.28	678.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	57,422.37	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	31,811.29	9,949.56	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,457.01	767.95	FEE SCHEDULE LAB	242,932.12	44,574.06
EKG/ECG	18,933.60	0.00	MRI SERVICES	1,497.00	1,497.00
IV THERAPY	41,438.43	1,848.38	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,470.22	736.80	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,687.92	191.76	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,125.26	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	541,796.11	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,501.38	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,642.50	4,161.50
RADIOLOGY THERAPEUTIC	18,984.00	1,355.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	500.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	103.16	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	64,168.68	13,710.30			
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	6,585.47	0.00			
			TOTAL ANCILLARY	1,073,860.08	80,073.47
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,073,860.08	80,073.47

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,329.93	ADJUSTMENTS	0.00
COVERED CHARGES	14,983.35	CONTRACTUAL ALLOW	5,440.79
NON-COVERD CHARGES	2,346.58	TOTAL MEDICAID LIAB	9,542.56
		LESS: COB	9,536.56
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	11

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	70.30	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	80.97	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,346.52	728.68
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	977.61	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	7,767.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	258.90	994.60
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	537.05	623.30			
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	945.00	0.00			
			TOTAL ANCILLARY	14,983.35	2,346.58
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,983.35	2,346.58

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,242,160.97	ADJUSTMENTS	140,015.09
COVERED CHARGES	1,836,149.07	CONTRACTUAL ALLOW	1,531,388.75
NON-COVERD CHARGES	406,011.90	TOTAL MEDICAID LIAB	304,760.32
		LESS: COB	4,497.79
		LESS: COPAYMENT	803.79
		REIMBURSEMENT	299,458.74
		TOTAL NUMBER OF CLAIMS	57

Report : CLM-0812-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,107.04	0.00	OTHER LAB	2,093.00	0.00
MED/SURG SUPPLY	56,914.72	25,837.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	45,247.90	1,593.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	72,384.00	2,320.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	740.98	FEE SCHEDULE LAB	41,003.44	8,057.22
EKG/ECG	5,995.64	2,208.92	MRI SERVICES	0.00	0.00
IV THERAPY	46,742.96	910.53	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	236,070.07	50,120.28	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	251.51	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	40,275.54	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,240.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	26,165.84	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	310,308.50	50,561.60
RADIOLOGY THERAPEUTIC	607,015.29	1,750.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	451.56	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	798.24	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	24,733.00	206,312.00
LITHOTRIPSY	18,897.60	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,616.75	2,159.70			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,458.00	7,747.56			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,068.00	1,752.32			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	231,873.16	43,040.90			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	27,888.87	447.83			
			TOTAL ANCILLARY	1,836,149.07	406,011.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,836,149.07	406,011.90

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	39,222.61	ADJUSTMENTS	0.00
COVERED CHARGES	28,226.75	CONTRACTUAL ALLOW	18,217.34
NON-COVERD CHARGES	10,995.86	TOTAL MEDICAID LIAB	10,009.41
		LESS: COB	10,000.41
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	351.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,619.63	412.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	583.22	0.00
EKG/ECG	315.56	315.56	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	375.00	1,714.10
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	3,100.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	23,901.84	5,453.70			
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	1,080.00	0.00			
			TOTAL ANCILLARY	28,226.75	10,995.86
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	28,226.75	10,995.86

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,204,410.99	ADJUSTMENTS	181,413.54
COVERED CHARGES	11,054,266.15	CONTRACTUAL ALLOW	6,399,426.26
NON-COVERD CHARGES	150,144.84	TOTAL MEDICAID LIAB	4,654,839.89
		LESS: COB	11,510.74
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,643,329.15

TOTAL NUMBER OF ADMISSIONS 594

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	999		2	731,268.00		98,576.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	999		2	731,268.00		98,576.00
SPECIAL CARE SERVICES						
CCU	11		0	10,263.00		0.00
ICU	1,721		0	1,751,223.84		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	11		0	8,787.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,743		0	1,770,273.84		0.00
TOTAL ACCOMODATIONS	2,742		2	2,501,541.84		98,576.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	643,845.74	0.00	OTHER LAB	89,016.10	0.00
MED/SURG SUPPLY	203,548.98	1,741.41	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,947,998.66	1,488.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	277,238.08	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	600,573.20	5,021.99	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	91,202.48	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	143,264.24	0.00	MRI SERVICES	86,787.00	0.00
IV THERAPY	408,208.18	259.62	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	329,400.89	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	805,159.30	1,654.56	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	94,850.59	0.00	AMBULANCE	0.00	0.00
GI SERVICES	85,598.97	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	680,933.07	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	65,004.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	65,144.62	0.00	INJECTABLE DRUGS	1,107,871.30	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	40,140.04	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	36,469.08	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	65,556.00	3,813.58	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	103.16	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	319.00	0.00	IMPL DEV CHARGE PATIENTS	46,971.66	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	367.50
OTHER IMAGING SERVICE	130,868.37	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	146,302.00	6,025.88			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	124,954.59	31,196.30			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	173,379.11	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	8,178.32	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	53,836.98	0.00			
			TOTAL ANCILLARY	8,552,724.31	51,568.84
			TOTAL ACCOMODATIONS	2,501,541.84	98,576.00
			TOTAL CHARGES	11,054,266.15	150,144.84

Report : CLM-0800-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
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SUMMARY TYPE I
INPATIENT PAID CLAIMS

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
6366	2214115006839	04/20/14 - 04/22/14	04/28/14	0.00	367.50	0.00	0.00	0.00
TOTAL				0.00	367.50	0.00	0.00	0.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,714.47	ADJUSTMENTS	0.00
COVERED CHARGES	20,714.47	CONTRACTUAL ALLOW	5,731.38
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	14,983.09
		LESS: COB	14,983.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	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	4		0	3,732.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	4		0	3,732.00		0.00
TOTAL ACCOMODATIONS	4		0	3,732.00		0.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,234.20	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	505.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,625.73	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,055.18	0.00	OTHER THERAPEUTIC SVC	0.00	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	315.56	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,026.04	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,731.61	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,100.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,529.80	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	1,000.00	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	343.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	516.35	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	16,982.47	0.00
			TOTAL ACCOMODATIONS	3,732.00	0.00
			TOTAL CHARGES	20,714.47	0.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
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SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,208,220.08	ADJUSTMENTS	260,267.38
COVERED CHARGES	11,095,871.06	CONTRACTUAL ALLOW	8,936,535.59
NON-COVERD CHARGES	1,112,349.02	TOTAL MEDICAID LIAB	2,159,335.47
		LESS: COB	2,876.10
		LESS: COPAYMENT	3,134.25
		REIMBURSEMENT	2,153,325.12
		ALL OTHER	1,937,624.98
		FEE SCHEDULE-LAB	182,442.30
		INJECTABLE DRUGS	33,257.84

TOTAL NUMBER OF CLAIMS 5,334

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	180,402.28	1,314.90	OTHER LAB	98,278.12	670.45
MED/SURG SUPPLY	138,336.25	4,219.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	200.02	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	699,398.36	1,845.87	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	975,184.64	120,520.28	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	55,267.69	15,536.87	FEE SCHEDULE LAB	2,166,994.07	441,454.08
EKG/ECG	245,216.44	5,048.96	MRI SERVICES	237,415.00	12,164.55
IV THERAPY	628,918.07	59,283.57	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	359,354.16	99,656.38	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,407.60	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	94,594.64	40,664.59	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	135,506.19	0.00	AMBULANCE	0.00	0.00
GI SERVICES	63,150.16	17,554.96	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,323,325.35	5,421.02	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	121,766.01	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,301.80
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	210,170.40	87,964.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,910.90	4,027.68	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,385.03	3,160.95	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	7,813.58	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	2,360.78	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	29,222.00	19,483.94
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	654,053.81	93,099.06			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,360.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	184,209.65	48,600.96			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	107,646.22	14,904.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	6,443.22	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	371,954.80	4,070.57			
			TOTAL ANCILLARY	11,095,871.06	1,112,342.82
			TOTAL ACCOMODATIONS	0.00	6.20
			TOTAL CHARGES	11,095,871.06	1,112,349.02

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	236,517.61	ADJUSTMENTS	0.00
COVERED CHARGES	190,646.99	CONTRACTUAL ALLOW	83,008.12
NON-COVERD CHARGES	45,870.62	TOTAL MEDICAID LIAB	107,638.87
		LESS: COB	107,623.87
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 87

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,525.13	0.00	OTHER LAB	1,626.10	0.00
MED/SURG SUPPLY	2,331.50	131.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,508.29	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,142.78	16,786.17	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	320.00	1,813.58	FEE SCHEDULE LAB	48,058.07	8,053.29
EKG/ECG	3,471.16	0.00	MRI SERVICES	5,447.00	2,395.00
IV THERAPY	13,854.19	782.58	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,840.44	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	135.36	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,153.96	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	62,821.62	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,723.05	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,140.80	325.30
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	218.00	1,029.60	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	439.30	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	100.00	117.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,263.10	12,755.80			
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	1,242.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,966.44	0.00			
			TOTAL ANCILLARY	190,646.99	45,870.62
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	190,646.99	45,870.62

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,086,237.59	ADJUSTMENTS	1,808.96
COVERED CHARGES	1,034,333.12	CONTRACTUAL ALLOW	978,057.49
NON-COVERD CHARGES	51,904.47	TOTAL MEDICAID LIAB	56,275.63
		LESS: COB	0.01
		LESS: COPAYMENT	1,713.02
		REIMBURSEMENT	54,562.60
		TOTAL NUMBER OF CLAIMS	1,006

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,525.35	0.00	OTHER LAB	10,634.37	0.00
MED/SURG SUPPLY	1,575.25	260.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	56,485.81	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	26,332.91	6,302.17	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	320.00	599.00	FEE SCHEDULE LAB	211,253.26	36,851.34
EKG/ECG	15,146.88	0.00	MRI SERVICES	1,468.00	0.00
IV THERAPY	49,255.47	1,813.60	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,093.39	135.36	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	595,732.01	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,441.50	637.40
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	234.10	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	39,776.20	5,071.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,292.72	0.00			
			TOTAL ANCILLARY	1,034,333.12	51,904.47
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,034,333.12	51,904.47

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	208.25	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	297.56	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,806.54	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,803.36	973.88
EKG/ECG	631.12	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,873.23	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	9,060.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	402.10	156.10
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,160.35	999.35			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	21,242.51	2,129.33
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	21,242.51	2,129.33

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	209,477.43	ADJUSTMENTS	0.00
COVERED CHARGES	201,875.33	CONTRACTUAL ALLOW	178,843.51
NON-COVERD CHARGES	7,602.10	TOTAL MEDICAID LIAB	23,031.82
		LESS: COB	0.00
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	23,007.82

TOTAL NUMBER OF CLAIMS 4

Report : CLM-0812-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	500.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,757.84	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,299.31	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	973.19	88.26
EKG/ECG	631.12	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	19,312.60	6,940.44	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,857.60	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,803.37	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	374.80	573.40
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	146,285.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,080.00	0.00			
			TOTAL ANCILLARY	201,875.33	7,602.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	201,875.33	7,602.10

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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Page: 16

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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	61,343.02	ADJUSTMENTS	0.00
COVERED CHARGES	57,280.98	CONTRACTUAL ALLOW	22,129.08
NON-COVERD CHARGES	4,062.04	TOTAL MEDICAID LIAB	35,151.90
		LESS: COB	35,148.90
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

Report : CLM-0814-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:04:54
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	127.10	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	52.00	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	4,008.14	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,355.89	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,584.39	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8.60	53.90
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	54,153.00	0.00
LITHOTRIPTY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	57,280.98	4,062.04
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	57,280.98	4,062.04

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

DOCTORS HOSPITAL
 3651 WHEELER RD
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER 000000558A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	84,631,478.98	ADJUSTMENTS	8,985,054.25
COVERED CHARGES	79,267,296.57	CONTRACTUAL ALLOW	64,631,968.59
NON-COVERD CHARGES	5,364,182.41	TOTAL MEDICAID LIAB	14,635,327.98
		LESS: COB	61,694.30
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	14,573,633.68

TOTAL NUMBER OF ADMISSIONS 820

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,861		41	1,729,630.00		910,254.00
ROUTINE NURSERY	306		0	426,542.00		143,785.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,167		41	2,156,172.00		1,054,039.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,715		23	4,049,927.00		122,606.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	1,219		0	7,729,720.00		782,416.00
HOSPICE	0		0	0.00		0.00
REHAB	0		144	0.00		199,422.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,934		167	11,779,647.00		1,104,444.00
TOTAL ACCOMODATIONS	5,101		208	13,935,819.00		2,158,483.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

DOCTORS HOSPITAL
 3651 WHEELER RD
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER
 000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,613,824.18	290,801.62	OTHER LAB	206,940.64	6,257.70
MED/SURG SUPPLY	9,009,135.43	386,778.46	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,027,822.13	407,838.49	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	751,274.93	13,765.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,187,852.55	197,650.41	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	345,153.77	22,189.07	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	235,078.68	2,586.18	MRI SERVICES	206,513.30	0.00
IV THERAPY	79,757.48	6,433.93	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,076,031.08	490,558.12	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	245,018.68	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,192,845.15	102,031.90	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	169,048.71	6,550.41	CAST ROOM	0.00	0.00
EMERGENCY ROOM	884,205.73	18,303.93	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,272,163.53	57,689.42	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	235,077.13	3,392.45	INJECTABLE DRUGS	15,733,495.62	862,544.31
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	316,239.24	14,815.25	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	49,984.65	4,676.37	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	290,805.68	5,637.00	PATIENT CONVENIENCE	0.00	3,177.86
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	20,778.52	40,886.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	959,727.00	162.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	201,847.36	5,219.95			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	805,288.39	215,759.54			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	181,570.96	28,185.28			
AUDIOLOGY	0.00	10,073.34			
CARDIOLOGY	957,728.09	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	44,655.26	1,734.42			
ORGAN ACQUISITION	3,853.54	0.00			
TREATMENT/OBSERV. RM	27,760.16	0.00			
			TOTAL ANCILLARY	65,331,477.57	3,205,699.41
			TOTAL ACCOMODATIONS	13,935,819.00	2,158,483.00
			TOTAL CHARGES	79,267,296.57	5,364,182.41

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:05:15
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DOCTORS HOSPITAL
 3651 WHEELER RD
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER 000000558A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	53,397.79	ADJUSTMENTS	0.00
COVERED CHARGES	42,432.79	CONTRACTUAL ALLOW	32,359.87
NON-COVERD CHARGES	10,965.00	TOTAL MEDICAID LIAB	10,072.92
		LESS: COB	10,072.92
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5		0	4,955.00		10,965.00
ROUTINE NURSERY	0		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	4,955.00		10,965.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	4,955.00		10,965.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

DOCTORS HOSPITAL
 3651 WHEELER RD
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER
 000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	949.45	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,625.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,858.55	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	18,012.64	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,121.47	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	1,096.83	0.00	INJECTABLE DRUGS	6,813.85	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	37,477.79	0.00
			TOTAL ACCOMODATIONS	4,955.00	10,965.00
			TOTAL CHARGES	42,432.79	10,965.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:05:17
Page: 5

DOCTORS HOSPITAL
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/13 THROUGH 03/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,356,855.74	ADJUSTMENTS	86,524.27
COVERED CHARGES	11,734,215.25	CONTRACTUAL ALLOW	9,321,684.73
NON-COVERD CHARGES	1,622,640.49	TOTAL MEDICAID LIAB	2,412,530.52
		LESS: COB	3,552.14
		LESS: COPAYMENT	5,606.66
		REIMBURSEMENT	2,403,371.72
		ALL OTHER	2,262,120.34
		FEE SCHEDULE-LAB	105,710.61
		INJECTABLE DRUGS	35,540.77

TOTAL NUMBER OF CLAIMS 5,076

DOCTORS HOSPITAL
 3651 WHEELER RD
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER
 000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	206,363.90	525.67	OTHER LAB	66,066.68	3,270.98
MED/SURG SUPPLY	513,699.45	15,633.38	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	610,649.52	2,991.59	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	953,473.66	255,602.66	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	40,736.98	46,524.33	FEE SCHEDULE LAB	1,020,475.51	176,320.03
EKG/ECG	206,751.42	10,164.30	MRI SERVICES	130,856.16	7,103.30
IV THERAPY	510,061.13	86,438.76	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,034,732.50	573,563.41	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	351,872.87	18,885.82	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	109,020.41	464.33	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	367,448.48	57,588.07	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,094,839.94	42,474.09	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	650,962.20	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	273,048.49	36,305.68
RADIOLOGY THERAPEUTIC	236,137.08	5,438.31	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	9,107.74	11,926.51	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,415.44	554.44	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	189,415.75	8,325.51	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	13,274.25	19,370.25
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	387,052.12	33,140.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,216.98	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	375,971.27	71,049.18			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	115,812.79	102,574.84			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	8,400.34	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	247,352.19	36,404.25			
			TOTAL ANCILLARY	11,734,215.25	1,622,640.49
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,734,215.25	1,622,640.49

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DOCTORS HOSPITAL
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/13 THROUGH 03/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	509,803.64	ADJUSTMENTS	0.00
COVERED CHARGES	337,978.39	CONTRACTUAL ALLOW	220,991.18
NON-COVERD CHARGES	171,825.25	TOTAL MEDICAID LIAB	116,987.21
		LESS: COB	116,929.72
		LESS: COPAYMENT	57.49
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 119

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DOCTORS HOSPITAL
 3651 WHEELER RD
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER
 000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,028.78	0.00	OTHER LAB	684.06	0.00
MED/SURG SUPPLY	36,855.75	1,780.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,832.95	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,027.62	39,970.42	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	626.13	FEE SCHEDULE LAB	18,216.62	2,613.53
EKG/ECG	4,510.78	0.00	MRI SERVICES	5,156.98	15,470.84
IV THERAPY	12,043.83	522.06	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	71,120.46	97,981.22	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	17,721.92	4,121.47	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,159.80	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,266.87	3,482.06	CAST ROOM	0.00	0.00
EMERGENCY ROOM	58,806.24	1,545.56	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	43,705.16	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,787.86	1,171.21
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,775.44	101.15	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	38.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,860.79	1,096.85			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,494.21	1,342.50			
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	9,883.77	0.00			
			TOTAL ANCILLARY	337,978.39	171,825.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	337,978.39	171,825.25

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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Page: 9

DOCTORS HOSPITAL
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/13 THROUGH 03/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	582,749.82	ADJUSTMENTS	105.88
COVERED CHARGES	554,537.74	CONTRACTUAL ALLOW	527,966.24
NON-COVERD CHARGES	28,212.08	TOTAL MEDICAID LIAB	26,571.50
		LESS: COB	54.81
		LESS: COPAYMENT	810.01
		REIMBURSEMENT	25,706.68
		TOTAL NUMBER OF CLAIMS	475

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL
 3651 WHEELER RD
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER
 000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,255.37	8.49	OTHER LAB	2,104.32	0.00
MED/SURG SUPPLY	5,167.00	100.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,677.80	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	25,276.85	5,494.40	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	553.53	FEE SCHEDULE LAB	48,411.52	12,650.47
EKG/ECG	13,953.36	1,323.16	MRI SERVICES	0.00	0.00
IV THERAPY	35,303.34	4,317.67	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	478.93	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,637.98	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	363,934.97	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18,712.40	2,574.03
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	143.27	93.23	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,480.63	1,096.85			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	554,537.74	28,212.08
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	554,537.74	28,212.08

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/13 THROUGH 03/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	33,089.29	ADJUSTMENTS	0.00
COVERED CHARGES	31,366.84	CONTRACTUAL ALLOW	16,362.08
NON-COVERD CHARGES	1,722.45	TOTAL MEDICAID LIAB	15,004.76
		LESS: COB	14,977.76
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	21

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:06:00
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SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL
 3651 WHEELER RD
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER
 000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	109.58	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	117.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,127.27	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,169.66	1,499.39
EKG/ECG	1,864.46	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,621.18	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	427.95	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	18,142.59	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	593.20	223.06
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	2,193.70	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	31,366.84	1,722.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	31,366.84	1,722.45

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DOCTORS HOSPITAL
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/13 THROUGH 03/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,139,810.39	ADJUSTMENTS	27,661.55
COVERED CHARGES	4,889,662.90	CONTRACTUAL ALLOW	4,112,815.15
NON-COVERD CHARGES	250,147.49	TOTAL MEDICAID LIAB	776,847.75
		LESS: COB	824.14
		LESS: COPAYMENT	792.00
		REIMBURSEMENT	775,231.61
		TOTAL NUMBER OF CLAIMS	150

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DOCTORS HOSPITAL
 3651 WHEELER RD
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER
 000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	126,005.02	53.34	OTHER LAB	0.00	697.57
MED/SURG SUPPLY	359,222.91	12,253.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,092.77	347.37	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	52,287.38	10,281.12	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	471.35	FEE SCHEDULE LAB	69,841.75	1,099.66
EKG/ECG	6,315.10	2,405.76	MRI SERVICES	3,729.25	0.00
IV THERAPY	6,917.19	5,966.63	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,487,681.44	166,322.62	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	51,776.47	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,415.88	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	712,728.09	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,196.02	27,343.38
RADIOLOGY THERAPEUTIC	627,657.12	2,161.29	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,124.73	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	20,056.79	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	183,750.50	17,489.00
LITHOTRIPSY	106,376.06	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,570.24	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	475.16	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,357.02	1,130.42			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,972.77	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,237.97	0.00			
			TOTAL ANCILLARY	4,889,662.90	250,147.49
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,889,662.90	250,147.49

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DOCTORS HOSPITAL
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER
000000558A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/13	THROUGH	03/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:06:13
 Page: 1

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,134,926.10	ADJUSTMENTS	49,054.12
COVERED CHARGES	3,043,504.35	CONTRACTUAL ALLOW	1,632,855.24
NON-COVERD CHARGES	91,421.75	TOTAL MEDICAID LIAB	1,410,649.11
		LESS: COB	14,619.88
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,396,029.23

TOTAL NUMBER OF ADMISSIONS 232

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	676		0	489,500.00		51,375.00
ROUTINE NURSERY	31		0	13,485.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		2,250.00
TOTAL ROUTINE	707		0	502,985.00		53,625.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	135		0	197,100.00		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	135		0	197,100.00		0.00
TOTAL ACCOMODATIONS	842		0	700,085.00		53,625.00

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	335,653.77	0.00	OTHER LAB	11,418.74	0.00
MED/SURG SUPPLY	322,425.94	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	526,931.33	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	54,663.52	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	128,918.88	18,715.05	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	20,410.17	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	42,176.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	61,987.44	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	138,494.32	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	39,151.73	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	146,624.23	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	73,650.35	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,850.33	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	133,150.95	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,212.04	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	109,170.15	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	1,857.02	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	97,869.78	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	14,583.06	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	34,729.77	18,785.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,157.39	295.95			
AUDIOLOGY	1,716.26	0.00			
CARDIOLOGY	21,750.65	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	470.44	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,394.59	0.00			
			TOTAL ANCILLARY	2,343,419.35	37,796.75
			TOTAL ACCOMODATIONS	700,085.00	53,625.00
			TOTAL CHARGES	3,043,504.35	91,421.75

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:06:15
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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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,300.54	ADJUSTMENTS	0.00
COVERED CHARGES	11,200.54	CONTRACTUAL ALLOW	4,682.82
NON-COVERD CHARGES	100.00	TOTAL MEDICAID LIAB	6,517.72
		LESS: COB	6,517.72
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	4		0	2,900.00		100.00
ROUTINE NURSERY	3		0	1,305.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	7		0	4,205.00		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	7		0	4,205.00		100.00

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,210.66	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,674.69	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,901.44	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	326.80	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	681.36	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	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	1,078.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	122.59	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,995.54	0.00
			TOTAL ACCOMODATIONS	4,205.00	100.00
			TOTAL CHARGES	11,200.54	100.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:06:16
Page: 5

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,983,310.01	ADJUSTMENTS	88,128.82
COVERED CHARGES	3,745,552.86	CONTRACTUAL ALLOW	2,977,423.46
NON-COVERD CHARGES	237,757.15	TOTAL MEDICAID LIAB	768,129.40
		LESS: COB	594.25
		LESS: COPAYMENT	2,879.39
		REIMBURSEMENT	764,655.76
		ALL OTHER	687,759.94
		FEE SCHEDULE-LAB	74,005.91
		INJECTABLE DRUGS	2,889.91
		TOTAL NUMBER OF CLAIMS	2,590

DODGE COUNTY HOSPITAL
 901 GRIFFIN AVE
 EASTMAN,GA 31023-6720

PROVIDER NUMBER
 000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	93,878.10	15,000.48	OTHER LAB	104,809.70	0.00
MED/SURG SUPPLY	288,259.34	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	199.62	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	199,416.68	862.65	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	438,076.93	8,698.07	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	13,857.14	1,530.02	FEE SCHEDULE LAB	694,243.73	177,705.32
EKG/ECG	75,345.30	1,567.80	MRI SERVICES	136,859.56	0.00
IV THERAPY	164,260.50	4,806.52	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	154,746.66	4,371.49	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	77,482.52	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	23,221.00	1,360.29	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	140,524.95	0.00	AMBULANCE	0.00	0.00
GI SERVICES	37,543.13	1,408.09	CAST ROOM	0.00	0.00
EMERGENCY ROOM	809,294.84	3,001.19	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	27,055.14	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	40,964.17	8,021.93
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	422.05	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	19,053.77	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	52,911.54	2,768.06			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,035.14	3,757.15			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	31,300.46	2,124.85			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	38,695.16	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,411.32	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	73,306.08	151.57			
			TOTAL ANCILLARY	3,745,552.86	237,757.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,745,552.86	237,757.15

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	45,031.26	ADJUSTMENTS	0.00
COVERED CHARGES	37,642.26	CONTRACTUAL ALLOW	28,589.56
NON-COVERD CHARGES	7,389.00	TOTAL MEDICAID LIAB	9,052.70
		LESS: COB	9,028.70
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 23

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	498.74	296.10	OTHER LAB	5,240.63	0.00
MED/SURG SUPPLY	2,748.51	125.20	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,562.81	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,935.51	4,097.73	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,726.52	2,525.16
EKG/ECG	588.20	261.30	MRI SERVICES	1,797.23	0.00
IV THERAPY	2,228.34	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,075.55	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	492.69	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	156.84	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	874.18	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,293.90	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	243.74	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	449.52	83.51
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	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,729.35	0.00			
			TOTAL ANCILLARY	37,642.26	7,389.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	37,642.26	7,389.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

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DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	200,147.05	ADJUSTMENTS	267.70
COVERED CHARGES	197,688.13	CONTRACTUAL ALLOW	183,367.49
NON-COVERD CHARGES	2,458.92	TOTAL MEDICAID LIAB	14,320.64
		LESS: COB	0.00
		LESS: COPAYMENT	585.00
		REIMBURSEMENT	13,735.64
		TOTAL NUMBER OF CLAIMS	256

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,309.24	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,009.61	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,569.87	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,459.36	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,724.42	1,940.10
EKG/ECG	2,352.80	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,076.18	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	788.05	78.42	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	146,607.41	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,634.33	440.40
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	156.86	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	197,688.13	2,458.92
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	197,688.13	2,458.92

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,615.11	ADJUSTMENTS	0.00
COVERED CHARGES	2,440.51	CONTRACTUAL ALLOW	1,576.72
NON-COVERD CHARGES	174.60	TOTAL MEDICAID LIAB	863.79
		LESS: COB	857.79
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34.36	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	141.88	174.60
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,051.28	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	212.99	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,440.51	174.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,440.51	174.60

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:06:30
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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	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF 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 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,893,392.04	ADJUSTMENTS	156,952.28
COVERED CHARGES	1,827,586.65	CONTRACTUAL ALLOW	754,791.11
NON-COVERD CHARGES	65,805.39	TOTAL MEDICAID LIAB	1,072,795.54
		LESS: COB	14,744.88
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,058,050.66

TOTAL NUMBER OF ADMISSIONS 144

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	304		0	136,680.00		19,475.00
ROUTINE NURSERY	30		0	7,800.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	334		0	144,480.00		19,475.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	122		0	146,400.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	122		0	146,400.00		0.00
TOTAL ACCOMODATIONS	456		0	290,880.00		19,475.00

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	349,917.75	5,004.50	OTHER LAB	8,222.50	0.00
MED/SURG SUPPLY	143,418.86	6,016.64	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	237,656.25	1,569.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	34,851.00	1,077.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	112,707.00	824.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,075.79	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	27,163.00	0.00	MRI SERVICES	14,429.00	0.00
IV THERAPY	735.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	80,427.75	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,620.75	4,830.75	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	120,691.50	626.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,896.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	86,660.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,863.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,165.25	0.00	INJECTABLE DRUGS	218,191.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	510.75	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,549.75	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	651.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,935.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	24,983.75	4,378.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	117.00			
AUDIOLOGY	552.50	0.00			
CARDIOLOGY	25,012.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,758.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	60.00	21,887.50			
			TOTAL ANCILLARY	1,536,706.65	46,330.39
			TOTAL ACCOMODATIONS	290,880.00	19,475.00
			TOTAL CHARGES	1,827,586.65	65,805.39

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,369.68	ADJUSTMENTS	0.00
COVERED CHARGES	14,886.18	CONTRACTUAL ALLOW	6,586.54
NON-COVERD CHARGES	483.50	TOTAL MEDICAID LIAB	8,299.64
		LESS: COB	8,299.64
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2		0	900.00		50.00
ROUTINE NURSERY	0		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	900.00		50.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	900.00		50.00

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 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	992.00	165.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,306.68	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,042.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,154.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	281.25	268.50	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	106.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	743.50	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	1,004.50	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.	909.75	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	13,986.18	433.50
			TOTAL ACCOMODATIONS	900.00	50.00
			TOTAL CHARGES	14,886.18	483.50

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

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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 08/01/13 THROUGH 07/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,491,974.79	ADJUSTMENTS	71,823.19
COVERED CHARGES	2,103,117.85	CONTRACTUAL ALLOW	1,319,592.63
NON-COVERD CHARGES	388,856.94	TOTAL MEDICAID LIAB	783,525.22
		LESS: COB	1,683.85
		LESS: COPAYMENT	1,435.24
		REIMBURSEMENT	780,406.13
		ALL OTHER	697,825.67
		FEE SCHEDULE-LAB	78,850.42
		INJECTABLE DRUGS	3,730.04

TOTAL NUMBER OF CLAIMS 2,351

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 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63,354.79	56,955.19	OTHER LAB	13,829.50	65.00
MED/SURG SUPPLY	82,141.05	1,242.64	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,165.75	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	104,865.75	2,621.25	OTHER THERAPEUTIC SVC	0.00	1,278.00
CT SCAN	298,194.75	39,094.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,937.75	2,620.75	FEE SCHEDULE LAB	487,034.76	131,954.84
EKG/ECG	41,436.50	5,401.00	MRI SERVICES	53,259.50	4,137.75
IV THERAPY	90,219.00	10,929.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	92,883.75	22,865.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	18,877.50	514.25	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	17,802.75	11,529.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,844.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	391,020.75	7,730.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,898.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	56,803.75	21,926.52
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	653.25	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,654.25	2,655.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	2,136.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	10.00
OTHER IMAGING SERVICE	61,849.50	6,316.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,551.75	1,640.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	47,158.50	8,707.25			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	23,497.25	32,625.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	67,033.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	30,368.25	12,082.00			
			TOTAL ANCILLARY	2,103,117.85	388,856.94
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,103,117.85	388,856.94

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

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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 08/01/13 THROUGH 07/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
1885	5914006001081	10/14/13 - 10/15/13	01/13/14	0.00	10.00	0.00	0.00	0.00
TOTAL				0.00	10.00	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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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 08/01/13 THROUGH 07/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,067.30	ADJUSTMENTS	0.00
COVERED CHARGES	11,212.55	CONTRACTUAL ALLOW	3,330.61
NON-COVERD CHARGES	8,854.75	TOTAL MEDICAID LIAB	7,881.94
		LESS: COB	7,869.31
		LESS: COPAYMENT	12.63
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 19

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 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	135.00	151.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	333.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	597.50	0.00	OTHER THERAPEUTIC SVC	0.00	53.25
CT SCAN	2,500.00	5,644.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,938.25	1,299.25
EKG/ECG	180.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	210.00	0.00	PROFESSIONAL FEES	0.00	72.50
OPERATING ROOM	0.00	824.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	229.25	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,543.75	159.75	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	396.50	332.50
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	149.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	318.50			
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	11,212.55	8,854.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,212.55	8,854.75

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

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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 08/01/13 THROUGH 07/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	334,650.08	ADJUSTMENTS	2,191.54
COVERED CHARGES	310,049.58	CONTRACTUAL ALLOW	281,632.06
NON-COVERD CHARGES	24,600.50	TOTAL MEDICAID LIAB	28,417.52
		LESS: COB	84.21
		LESS: COPAYMENT	999.01
		REIMBURSEMENT	27,334.30
		TOTAL NUMBER OF CLAIMS	508

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 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,900.50	7,292.18	OTHER LAB	371.50	0.00
MED/SURG SUPPLY	4,194.58	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,852.50	265.50	OTHER THERAPEUTIC SVC	0.00	50.00
CT SCAN	44,973.75	4,531.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	60,743.00	9,238.00
EKG/ECG	5,040.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,475.00	945.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	113.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	615.50	704.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	145,477.50	170.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,063.25	1,224.32
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	180.00
OTHER IMAGING SERVICE	3,795.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	434.50	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	310,049.58	24,600.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	310,049.58	24,600.50

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 08/01/13 THROUGH 07/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
4258	5914344002500	05/07/14 - 05/07/14	12/15/14	0.00	180.00	0.00	0.00	0.00
TOTAL				0.00	180.00	0.00	0.00	0.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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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 08/01/13 THROUGH 07/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,283.14	ADJUSTMENTS	0.00
COVERED CHARGES	3,483.89	CONTRACTUAL ALLOW	882.64
NON-COVERD CHARGES	1,799.25	TOTAL MEDICAID LIAB	2,601.25
		LESS: COB	2,592.25
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

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 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	169.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	89.89	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	200.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,200.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,099.00	32.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,990.00	53.25	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	105.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	345.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,483.89	1,799.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,483.89	1,799.25

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 08/01/13 THROUGH 07/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	50,935.37	ADJUSTMENTS	0.00
COVERED CHARGES	49,511.87	CONTRACTUAL ALLOW	33,426.82
NON-COVERD CHARGES	1,423.50	TOTAL MEDICAID LIAB	16,085.05
		LESS: COB	0.00
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	16,067.05

TOTAL NUMBER OF CLAIMS 3

Report : CLM-0812-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:06:53
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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 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,105.00	245.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,817.62	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,211.00	210.50
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	985.00	210.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,814.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	266.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,433.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	600.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,210.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18,733.00	158.00
RADIOLOGY THERAPEUTIC	1,480.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	393.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	345.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	189.75	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	528.00	0.00			
			TOTAL ANCILLARY	49,511.87	1,423.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	49,511.87	1,423.50

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:06:54
Page: 17

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	08/01/13	THROUGH	07/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF 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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,872,721.26	ADJUSTMENTS	921,005.23
COVERED CHARGES	19,535,077.77	CONTRACTUAL ALLOW	14,169,649.18
NON-COVERD CHARGES	337,643.49	TOTAL MEDICAID LIAB	5,365,428.59
		LESS: COB	38,007.60
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,327,420.99

TOTAL NUMBER OF ADMISSIONS 640

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	912	24	924,768.00	119,653.00
ROUTINE NURSERY	151	0	56,562.00	202.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,063	24	981,330.00	119,855.00
SPECIAL CARE SERVICES				
CCU	1,150	15	1,778,445.36	23,130.00
ICU	278	2	795,080.00	5,720.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,428	17	2,573,525.36	28,850.00
TOTAL ACCOMODATIONS	2,491	41	3,554,855.36	148,705.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,540,927.03	13,828.00	OTHER LAB	148,611.00	0.00
MED/SURG SUPPLY	627,909.15	5,532.49	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,037,229.56	1,322.00	EDUCATION & TRAINING	3,597.00	0.00
RADIOLOGY-DIAGNOSTIC	435,765.24	0.00	OTHER THERAPEUTIC SVC	0.00	645.00
CT SCAN	1,263,103.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	50,271.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	181,752.00	0.00	MRI SERVICES	281,235.00	0.00
IV THERAPY	461,856.31	40,508.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	746,536.84	13,589.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	581,771.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,652,558.00	949.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	276,663.85	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,120,854.00	1,837.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	164,503.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	69,977.00	0.00	INJECTABLE DRUGS	974.00	0.00
RADIOLOGY THERAPEUTIC	2,079.55	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	20,076.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	741,985.80	11,210.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	20,400.00	796.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	16,645.40	402.00	IMPL DEV CHARGE PATIENTS	78,691.14	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	35,203.00
OTHER IMAGING SERVICE	147,765.46	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	158,782.72	54,208.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	313,304.00	7,545.00			
AUDIOLOGY	26,936.00	0.00			
CARDIOLOGY	710,182.00	1,364.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	54,216.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	43,064.36	0.00			
			TOTAL ANCILLARY	15,980,222.41	188,938.49
			TOTAL ACCOMODATIONS	3,554,855.36	148,705.00
			TOTAL CHARGES	19,535,077.77	337,643.49

Report : CLM-0800-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:07:02
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WELLSTAR DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013254070511	09/01/13 - 09/04/13	09/16/13	0.00	6,862.00	0.00	0.00	0.00
615	2013347053095	11/30/13 - 12/04/13	12/23/13	0.00	6,862.00	0.00	0.00	0.00
615	2014062048102	02/19/14 - 02/21/14	03/10/14	0.00	7,755.00	0.00	0.00	0.00
615	2014083039984	03/11/14 - 03/15/14	03/31/14	0.00	6,862.00	0.00	0.00	0.00
615	2015134077229	10/23/13 - 10/24/13	05/18/15	0.00	6,862.00	0.00	0.00	0.00
TOTAL				0.00	35,203.00	0.00	0.00	0.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:07:07
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,477.50	ADJUSTMENTS	0.00
COVERED CHARGES	12,376.50	CONTRACTUAL ALLOW	646.30
NON-COVERD CHARGES	101.00	TOTAL MEDICAID LIAB	11,730.20
		LESS: COB	11,730.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1		0	1,014.00		101.00
ROUTINE NURSERY	0		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	1,014.00		101.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	1,014.00		101.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 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	263.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	856.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,720.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	226.00	0.00			
			TOTAL ANCILLARY	11,362.50	0.00
			TOTAL ACCOMODATIONS	1,014.00	101.00
			TOTAL CHARGES	12,376.50	101.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:07:09
Page: 6

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

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,864,113.23	ADJUSTMENTS	389,942.67
COVERED CHARGES	12,538,182.51	CONTRACTUAL ALLOW	10,133,818.58
NON-COVERD CHARGES	1,325,930.72	TOTAL MEDICAID LIAB	2,404,363.93
		LESS: COB	2,923.34
		LESS: COPAYMENT	3,040.46
		REIMBURSEMENT	2,398,400.13
		ALL OTHER	2,148,081.95
		FEE SCHEDULE-LAB	202,414.93
		INJECTABLE DRUGS	47,903.25
		TOTAL NUMBER OF CLAIMS	5,611

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	221,297.02	53,074.00	OTHER LAB	119,717.00	0.00
MED/SURG SUPPLY	127,737.22	34,502.59	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	2,640.00	EDUCATION & TRAINING	228.00	0.00
RADIOLOGY-DIAGNOSTIC	851,686.00	12,890.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,831,156.40	143,464.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,767.00	729.00	FEE SCHEDULE LAB	2,173,823.51	293,927.49
EKG/ECG	183,700.00	3,104.00	MRI SERVICES	311,673.00	52,137.00
IV THERAPY	368,946.75	122,607.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	531,221.00	93,343.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	150,551.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	107,027.00	44,981.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	232,387.00	1,833.00	AMBULANCE	0.00	0.00
GI SERVICES	1,982.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,381,517.00	55,480.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	151,150.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	310,502.00	185,344.00
RADIOLOGY THERAPEUTIC	11,530.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,250.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	11,210.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,537.00	4,595.34	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	67,702.00	0.00	IMPL DEV CHARGE PATIENTS	7,582.24	44,450.80
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	22.00
OTHER IMAGING SERVICE	492,591.00	39,751.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	24,582.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	290,357.00	8,189.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	194,428.00	104,944.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	267,894.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	113,910.37	11,462.50			
			TOTAL ANCILLARY	12,538,182.51	1,325,930.72
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,538,182.51	1,325,930.72

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:07:09
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WELLSTAR DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3305	5914168000048	05/02/14 - 05/02/14	06/23/14	0.00	22.00	0.00	0.00	0.00
TOTAL				0.00	22.00	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:07:28
Page: 9

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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	51,570.78	ADJUSTMENTS	0.00
COVERED CHARGES	48,247.19	CONTRACTUAL ALLOW	36,852.52
NON-COVERD CHARGES	3,323.59	TOTAL MEDICAID LIAB	11,394.67
		LESS: COB	11,378.90
		LESS: COPAYMENT	15.77
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 27

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	620.00	0.00	OTHER LAB	1,173.00	0.00
MED/SURG SUPPLY	254.11	49.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,970.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,726.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,483.58	859.84
EKG/ECG	1,552.00	388.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,544.00	607.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,703.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,974.00	722.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,858.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	289.50	76.75
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	2,100.00	621.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	48,247.19	3,323.59
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	48,247.19	3,323.59

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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WELLSTAR DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,450,619.19	ADJUSTMENTS	1,823.96
COVERED CHARGES	1,385,911.69	CONTRACTUAL ALLOW	1,333,495.92
NON-COVERD CHARGES	64,707.50	TOTAL MEDICAID LIAB	52,415.77
		LESS: COB	0.00
		LESS: COPAYMENT	1,656.05
		REIMBURSEMENT	50,759.72
		TOTAL NUMBER OF CLAIMS	937

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,296.75	3,120.00	OTHER LAB	26,322.00	1,173.00
MED/SURG SUPPLY	2,668.19	142.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	76,225.00	528.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	108,703.00	17,721.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	266,185.00	18,662.00
EKG/ECG	13,192.00	388.00	MRI SERVICES	8,725.00	0.00
IV THERAPY	35,733.00	15,628.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,907.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,441.00	2,166.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	737,528.00	175.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,345.75	1,945.50
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	100.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	20,774.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	45,866.00	1,595.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,364.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,385,911.69	64,707.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,385,911.69	64,707.50

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,659.00	1,027.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,562.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,595.00	621.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,816.00	1,648.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,816.00	1,648.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:07:36
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	323,111.85	ADJUSTMENTS	5,142.52
COVERED CHARGES	262,165.73	CONTRACTUAL ALLOW	208,187.77
NON-COVERD CHARGES	60,946.12	TOTAL MEDICAID LIAB	53,977.96
		LESS: COB	0.00
		LESS: COPAYMENT	42.00
		REIMBURSEMENT	53,935.96
		TOTAL NUMBER OF CLAIMS	10

Report : CLM-0812-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,707.50	375.00	OTHER LAB	1,824.00	0.00
MED/SURG SUPPLY	8,366.48	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,742.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,267.00	2,693.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,385.00	2,302.00
EKG/ECG	1,164.00	0.00	MRI SERVICES	6,862.00	4,467.00
IV THERAPY	1,975.00	3,828.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	20,284.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,243.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,505.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,755.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	71,306.75	32,920.00
RADIOLOGY THERAPEUTIC	9,864.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	100.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	349.00	5,173.00
LITHOTRIPSY	68,318.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,734.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	18,264.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,250.00	5,998.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	3,090.12			
			TOTAL ANCILLARY	262,165.73	60,946.12
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	262,165.73	60,946.12

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:07:38
Page: 17

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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC
 11740 COLUMBIA ST
 BLAKELY, GA 39823-2574

PROVIDER NUMBER 000000635A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	299,274.72	ADJUSTMENTS	0.00
COVERED CHARGES	284,847.72	CONTRACTUAL ALLOW	128,351.71
NON-COVERD CHARGES	14,427.00	TOTAL MEDICAID LIAB	156,496.01
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	156,496.01

TOTAL NUMBER OF ADMISSIONS 33

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	114		0	61,560.00		12,987.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	114		0	61,560.00		12,987.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	114		0	61,560.00		12,987.00

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC
 11740 COLUMBIA ST
 BLAKELY, GA 39823-2574

PROVIDER NUMBER
 000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,751.61	0.00	OTHER LAB	440.00	0.00
MED/SURG SUPPLY	18,801.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	46,171.00	0.00	EDUCATION & TRAINING	126.00	0.00
RADIOLOGY-DIAGNOSTIC	7,104.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	31,549.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,686.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	868.00	0.00	MRI SERVICES	2,405.00	0.00
IV THERAPY	3,223.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	19,602.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	25,693.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,218.11	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,089.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	553.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	880.00	0.00			
BLOOD	678.00	0.00			
BLOOD STORAGE & PRO.	678.00	1,440.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,772.00	0.00			
			TOTAL ANCILLARY	223,287.72	1,440.00
			TOTAL ACCOMODATIONS	61,560.00	12,987.00
			TOTAL CHARGES	284,847.72	14,427.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC
11740 COLUMBIA ST
BLAKELY,GA 39823-2574

PROVIDER NUMBER
000000635A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC
11740 COLUMBIA ST
BLAKELY,GA 39823-2574

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	741,109.04	ADJUSTMENTS	15,154.88
COVERED CHARGES	630,053.28	CONTRACTUAL ALLOW	445,967.23
NON-COVERD CHARGES	111,055.76	TOTAL MEDICAID LIAB	184,086.05
		LESS: COB	0.00
		LESS: COPAYMENT	1,157.83
		REIMBURSEMENT	182,928.22
		ALL OTHER	159,594.49
		FEE SCHEDULE-LAB	14,356.20
		INJECTABLE DRUGS	8,977.53

TOTAL NUMBER OF CLAIMS 732

Report : CLM-0804-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC
 11740 COLUMBIA ST
 BLAKELY, GA 39823-2574

PROVIDER NUMBER
 000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38,594.42	5,699.72	OTHER LAB	1,760.00	0.00
MED/SURG SUPPLY	6,901.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	7,658.00	EDUCATION & TRAINING	0.00	63.00
RADIOLOGY-DIAGNOSTIC	35,105.00	1,418.00	OTHER THERAPEUTIC SVC	0.00	840.00
CT SCAN	71,841.00	40,849.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,079.00	2,804.00	FEE SCHEDULE LAB	171,665.00	36,883.00
EKG/ECG	3,280.00	240.00	MRI SERVICES	4,572.00	0.00
IV THERAPY	6,769.00	222.00	PROFESSIONAL FEES	0.00	2,086.00
OPERATING ROOM	6,146.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,318.00	146.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	129.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	198,172.00	230.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	180.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	24,809.86	8,476.04
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	6,881.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	1,440.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	23,860.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	18,120.00	1,872.00			
			TOTAL ANCILLARY	630,053.28	111,055.76
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	630,053.28	111,055.76

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC
11740 COLUMBIA ST
BLAKELY,GA 39823-2574

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	693.59	ADJUSTMENTS	0.00
COVERED CHARGES	674.59	CONTRACTUAL ALLOW	298.59
NON-COVERD CHARGES	19.00	TOTAL MEDICAID LIAB	376.00
		LESS: COB	376.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC
 11740 COLUMBIA ST
 BLAKELY,GA 39823-2574

PROVIDER NUMBER
 000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 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	314.00	19.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	260.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	100.59	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	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	674.59	19.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	674.59	19.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

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PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC
11740 COLUMBIA ST
BLAKELY, GA 39823-2574

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	71,255.82	ADJUSTMENTS	0.00
COVERED CHARGES	64,612.45	CONTRACTUAL ALLOW	59,362.45
NON-COVERD CHARGES	6,643.37	TOTAL MEDICAID LIAB	5,250.00
		LESS: COB	0.00
		LESS: COPAYMENT	174.00
		REIMBURSEMENT	5,076.00
		TOTAL NUMBER OF CLAIMS	105

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC
 11740 COLUMBIA ST
 BLAKELY, GA 39823-2574

PROVIDER NUMBER
 000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,440.81	585.51	OTHER LAB	440.00	0.00
MED/SURG SUPPLY	436.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,148.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	4,424.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,081.00	934.00
EKG/ECG	137.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	81.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	47,879.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,050.64	618.86
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	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	64,612.45	6,643.37
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	64,612.45	6,643.37

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC
11740 COLUMBIA ST
BLAKELY,GA 39823-2574

PROVIDER NUMBER
000000635A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC
11740 COLUMBIA ST
BLAKELY,GA 39823-2574

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	36,243.03	ADJUSTMENTS	9,715.10
COVERED CHARGES	35,698.03	CONTRACTUAL ALLOW	25,973.93
NON-COVERD CHARGES	545.00	TOTAL MEDICAID LIAB	9,724.10
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	9,715.10

TOTAL NUMBER OF CLAIMS 2

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC
 11740 COLUMBIA ST
 BLAKELY, GA 39823-2574

PROVIDER NUMBER
 000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,102.45	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,691.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	358.00	0.00	OTHER THERAPEUTIC SVC	0.00	210.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,601.00	114.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,672.00	105.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,856.00	116.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,238.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	569.58	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,610.00	0.00			
			TOTAL ANCILLARY	35,698.03	545.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	35,698.03	545.00

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC
11740 COLUMBIA ST
BLAKELY,GA 39823-2574

PROVIDER NUMBER
000000635A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:08:01
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	567,644.64	ADJUSTMENTS	30,854.20
COVERED CHARGES	437,769.64	CONTRACTUAL ALLOW	258,429.80
NON-COVERD CHARGES	129,875.00	TOTAL MEDICAID LIAB	179,339.84
		LESS: COB	1,982.65
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	177,357.19

TOTAL NUMBER OF ADMISSIONS 28

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	67		1	55,275.00		106,392.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	67		1	55,275.00		106,392.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	67		1	55,275.00		106,392.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	59,638.90	0.00	OTHER LAB	4,469.00	0.00
MED/SURG SUPPLY	64,254.74	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	45,350.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,549.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,480.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,686.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	28,598.00	0.00	MRI SERVICES	8,291.00	0.00
IV THERAPY	453.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	64,805.00	20,287.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	29,622.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	21,126.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,768.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,128.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	82.00	0.00	INJECTABLE DRUGS	597.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	984.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,712.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,901.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	2,992.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	204.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	382,494.64	23,483.00
			TOTAL ACCOMODATIONS	55,275.00	106,392.00
			TOTAL CHARGES	437,769.64	129,875.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:08:02
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,452,809.39	ADJUSTMENTS	66,614.62
COVERED CHARGES	2,144,575.24	CONTRACTUAL ALLOW	1,515,856.34
NON-COVERD CHARGES	308,234.15	TOTAL MEDICAID LIAB	628,718.90
		LESS: COB	3,140.02
		LESS: COPAYMENT	1,334.94
		REIMBURSEMENT	624,243.94
		ALL OTHER	584,659.67
		FEE SCHEDULE-LAB	38,525.58
		INJECTABLE DRUGS	1,058.69
		TOTAL NUMBER OF CLAIMS	1,628

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	83,074.46	0.00	OTHER LAB	23,139.00	0.00
MED/SURG SUPPLY	69,795.78	209.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	237,930.00	2,881.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	241,430.00	162,659.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	16,340.00	3,166.00	FEE SCHEDULE LAB	367,528.00	91,412.40
EKG/ECG	34,240.00	9,178.00	MRI SERVICES	110,469.00	3,011.00
IV THERAPY	30.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	104,775.50	10,576.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	69,126.00	678.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	14,754.00	1,111.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	629,603.00	1,501.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	16,565.00	3,240.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,523.50	702.75
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	2,178.00	3,761.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	61,795.00	9,722.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	748.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,252.00	1,827.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,068.00	1,851.00			
AMBULATORY SURGERY	4,000.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	38,959.00	0.00			
			TOTAL ANCILLARY	2,144,575.24	308,234.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,144,575.24	308,234.15

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	50,295.00	ADJUSTMENTS	0.00
COVERED CHARGES	35,851.00	CONTRACTUAL ALLOW	15,280.50
NON-COVERD CHARGES	14,444.00	TOTAL MEDICAID LIAB	20,570.50
		LESS: COB	20,555.50
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 34

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	748.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	557.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,253.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,983.00	11,209.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,893.00	2,761.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	234.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,714.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	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	1,764.00	474.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	637.00	0.00			
			TOTAL ANCILLARY	35,851.00	14,444.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	35,851.00	14,444.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,713.18	0.00	OTHER LAB	2,890.00	0.00
MED/SURG SUPPLY	2,937.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,009.00	258.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,849.00	2,243.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	25,916.00	2,945.00
EKG/ECG	759.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,508.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	157,338.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	672.00	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	1,329.00	2,532.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,352.00	0.00			
			TOTAL ANCILLARY	221,272.18	8,020.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	221,272.18	8,020.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,476.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,446.00	CONTRACTUAL ALLOW	3,114.68
NON-COVERD CHARGES	30.00	TOTAL MEDICAID LIAB	1,331.32
		LESS: COB	1,331.32
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9.00	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	1,346.00	30.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,081.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,446.00	30.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,446.00	30.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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ELBERT MEMORIAL HOSPITAL
 4 MEDICAL DR
 ELBERTON,GA 30635-1830

PROVIDER NUMBER 000000668A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	605,967.05	ADJUSTMENTS	25,610.78
COVERED CHARGES	594,906.17	CONTRACTUAL ALLOW	255,623.38
NON-COVERD CHARGES	11,060.88	TOTAL MEDICAID LIAB	339,282.79
		LESS: COB	6,932.17
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	332,350.62

TOTAL NUMBER OF ADMISSIONS 58

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	197		0	119,776.00		10,124.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	197		0	119,776.00		10,124.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	16		0	19,280.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	19,280.00		0.00
TOTAL ACCOMODATIONS	213		0	139,056.00		10,124.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	91,784.86	0.00	OTHER LAB	2,901.62	0.00
MED/SURG SUPPLY	34,625.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	96,381.32	0.00	EDUCATION & TRAINING	66.00	0.00
RADIOLOGY-DIAGNOSTIC	21,063.18	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	33,516.31	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,493.01	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	11,940.96	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	14,233.27	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,000.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	60,252.18	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	173.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	38,076.96	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	395.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,293.05	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	6,752.89	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	153.00	0.00			
NUCLEAR MEDICINE	7,403.00	936.88			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	10,590.51	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,563.68	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,191.37	0.00			
			TOTAL ANCILLARY	455,850.17	936.88
			TOTAL ACCOMODATIONS	139,056.00	10,124.00
			TOTAL CHARGES	594,906.17	11,060.88

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,301,655.40	ADJUSTMENTS	25,697.32
COVERED CHARGES	1,209,901.75	CONTRACTUAL ALLOW	895,287.84
NON-COVERD CHARGES	91,753.65	TOTAL MEDICAID LIAB	314,613.91
		LESS: COB	1,263.60
		LESS: COPAYMENT	1,059.22
		REIMBURSEMENT	312,291.09
		ALL OTHER	288,988.01
		FEE SCHEDULE-LAB	23,153.45
		INJECTABLE DRUGS	149.63
		TOTAL NUMBER OF CLAIMS	1,054

ELBERT MEMORIAL HOSPITAL
 4 MEDICAL DR
 ELBERTON,GA 30635-1830

PROVIDER NUMBER
 000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	67,168.22	3,716.14	OTHER LAB	12,378.31	0.00
MED/SURG SUPPLY	14,471.50	184.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	343.60	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	94,397.25	819.92	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	139,766.65	8,173.30	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	18,523.83	6,124.06	FEE SCHEDULE LAB	226,191.31	34,840.26
EKG/ECG	20,282.68	940.09	MRI SERVICES	13,168.56	0.00
IV THERAPY	80,414.47	8,821.20	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	90,000.00	20,000.00	DURABLE MED. EQUIP.	0.00	187.50
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,864.17	62.76	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,265.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	320,178.17	2,388.24	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	15,800.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,955.55	1,086.85
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	62.00	0.00	IMPL DEV CHARGE PATIENTS	3,484.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	33,060.67	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,552.34	1,668.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,002.00	1,133.89			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	15,129.30	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,785.77	1,263.84			
			TOTAL ANCILLARY	1,209,901.75	91,753.65
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,209,901.75	91,753.65

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,727.34	ADJUSTMENTS	0.00
COVERED CHARGES	5,324.22	CONTRACTUAL ALLOW	1,295.91
NON-COVERD CHARGES	3,403.12	TOTAL MEDICAID LIAB	4,028.31
		LESS: COB	4,028.31
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 7

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	215.00	46.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	235.88	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,208.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,404.15	109.12
EKG/ECG	204.03	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	482.16	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,783.00	0.00	SPECIAL SERVICES	0.00	0.00
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	5,324.22	3,403.12
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,324.22	3,403.12

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

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ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	51,503.57	ADJUSTMENTS	161.82
COVERED CHARGES	50,714.86	CONTRACTUAL ALLOW	47,190.64
NON-COVERD CHARGES	788.71	TOTAL MEDICAID LIAB	3,524.22
		LESS: COB	0.00
		LESS: COPAYMENT	132.00
		REIMBURSEMENT	3,392.22
		TOTAL NUMBER OF CLAIMS	63

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,860.79	41.00	OTHER LAB	658.43	0.00
MED/SURG SUPPLY	230.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,770.34	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,140.30	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,196.65	536.98
EKG/ECG	736.06	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,071.71	182.73	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	162.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	488.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,332.08	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	68.00	28.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	50,714.86	788.71
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	50,714.86	788.71

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	533.18	ADJUSTMENTS	0.00
COVERED CHARGES	518.18	CONTRACTUAL ALLOW	173.18
NON-COVERD CHARGES	15.00	TOTAL MEDICAID LIAB	345.00
		LESS: COB	345.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 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	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	64.18	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	454.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	518.18	15.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	518.18	15.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF 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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,844,132.00	ADJUSTMENTS	8,673.10
COVERED CHARGES	2,814,475.40	CONTRACTUAL ALLOW	1,850,842.01
NON-COVERD CHARGES	29,656.60	TOTAL MEDICAID LIAB	963,633.39
		LESS: COB	12,192.47
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	951,440.92

TOTAL NUMBER OF ADMISSIONS 163

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	445		7	221,051.00		13,977.00
ROUTINE NURSERY	39		0	19,383.00		3,033.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	484		7	240,434.00		17,010.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	111		1	122,321.00		1,102.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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		1	122,321.00		1,102.00
TOTAL ACCOMODATIONS	595		8	362,755.00		18,112.00

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	860,351.57	0.00	OTHER LAB	10,730.00	0.00
MED/SURG SUPPLY	115,793.65	61.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	496,624.58	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	63,301.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	181,147.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,360.70	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	25,284.00	0.00	MRI SERVICES	14,573.00	0.00
IV THERAPY	21,164.00	0.00	PROFESSIONAL FEES	0.00	1,906.00
OPERATING ROOM	88,191.00	3,170.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	14,315.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	251,204.70	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	20,460.80	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	149,337.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	28,284.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,475.85	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,560.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	732.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,561.40	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,788.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,386.00	5,675.00			
ONCOLOGY	491.00	0.00			
NUCLEAR MEDICINE	16,182.00	0.00			
AUDIOLOGY	6,508.85	0.00			
CARDIOLOGY	36,967.30	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,678.00	0.00			
			TOTAL ANCILLARY	2,451,720.40	11,544.60
			TOTAL ACCOMODATIONS	362,755.00	18,112.00
			TOTAL CHARGES	2,814,475.40	29,656.60

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	41,444.40	ADJUSTMENTS	0.00
COVERED CHARGES	41,444.40	CONTRACTUAL ALLOW	30,778.81
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	10,665.59
		LESS: COB	10,665.59
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3		0	1,491.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3		0	1,491.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	6		0	6,612.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	6,612.00		0.00
TOTAL ACCOMODATIONS	9		0	8,103.00		0.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,534.20	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	809.65	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,564.60	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	958.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	240.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,870.95	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	1,162.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,202.00	0.00			
			TOTAL ANCILLARY	33,341.40	0.00
			TOTAL ACCOMODATIONS	8,103.00	0.00
			TOTAL CHARGES	41,444.40	0.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

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EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,019,840.05	ADJUSTMENTS	110,548.32
COVERED CHARGES	4,622,797.84	CONTRACTUAL ALLOW	3,621,520.12
NON-COVERD CHARGES	397,042.21	TOTAL MEDICAID LIAB	1,001,277.72
		LESS: COB	2,010.14
		LESS: COPAYMENT	2,331.00
		REIMBURSEMENT	996,936.58
		ALL OTHER	910,851.39
		FEE SCHEDULE-LAB	86,085.19
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	2,459

EMANUEL MEDICAL CENTER
 117 KITE RD
 SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
 000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	320,554.66	150.00	OTHER LAB	44,351.00	0.00
MED/SURG SUPPLY	118,220.80	1,849.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	262,623.00	1,485.00	OTHER THERAPEUTIC SVC	0.00	420.00
CT SCAN	523,657.00	28,778.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	212.80	FEE SCHEDULE LAB	1,047,784.38	243,385.55
EKG/ECG	55,644.00	1,272.00	MRI SERVICES	224,897.00	20,891.00
IV THERAPY	206,683.00	17,251.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	100,121.00	13,831.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,449.00	546.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	25,296.00	3,091.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,999.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,154,986.00	15,594.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	24,708.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	396.95	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,310.40	327.61	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	10,047.00	1,194.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	6,822.20
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	262,185.00	8,818.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,078.00	525.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,934.00	12,554.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	22,475.60	4,263.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	38,253.25	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	158,540.00	13,384.60			
			TOTAL ANCILLARY	4,622,797.84	397,042.21
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,622,797.84	397,042.21

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	35,484.61	ADJUSTMENTS	0.00
COVERED CHARGES	28,887.51	CONTRACTUAL ALLOW	14,513.36
NON-COVERD CHARGES	6,597.10	TOTAL MEDICAID LIAB	14,374.15
		LESS: COB	14,371.15
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 15

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,848.01	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	339.95	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	599.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,712.80	1,015.10
EKG/ECG	0.00	0.00	MRI SERVICES	4,012.00	5,164.00
IV THERAPY	1,026.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	546.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	143.75	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	5,904.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	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	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,647.00	418.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,705.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	807.00	0.00			
			TOTAL ANCILLARY	28,887.51	6,597.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	28,887.51	6,597.10

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

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EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	409,900.04	ADJUSTMENTS	205.76
COVERED CHARGES	397,431.24	CONTRACTUAL ALLOW	381,264.58
NON-COVERD CHARGES	12,468.80	TOTAL MEDICAID LIAB	16,166.66
		LESS: COB	0.00
		LESS: COPAYMENT	468.00
		REIMBURSEMENT	15,698.66
		TOTAL NUMBER OF CLAIMS	289

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,742.11	0.00	OTHER LAB	3,107.00	0.00
MED/SURG SUPPLY	3,129.25	266.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,081.00	0.00	OTHER THERAPEUTIC SVC	0.00	102.00
CT SCAN	21,156.00	2,782.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	77,499.18	7,062.50
EKG/ECG	3,552.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	18,349.00	552.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	806.70	199.50	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	223,074.00	361.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	23.80
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.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,073.00	1,120.00			
			TOTAL ANCILLARY	397,431.24	12,468.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	397,431.24	12,468.80

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	307.60	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	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,449.00	167.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	375.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,648.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,781.60	167.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,781.60	167.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,101.05	ADJUSTMENTS	0.00
COVERED CHARGES	23,105.45	CONTRACTUAL ALLOW	18,281.81
NON-COVERD CHARGES	1,995.60	TOTAL MEDICAID LIAB	4,823.64
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,823.64

TOTAL NUMBER OF CLAIMS 1

Report : CLM-0812-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,770.40	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	155.45	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	231.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,015.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,173.00	1,129.00
EKG/ECG	276.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	790.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	677.60	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	1,336.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	26.60
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,681.00	840.00			
			TOTAL ANCILLARY	23,105.45	1,995.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	23,105.45	1,995.60

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF 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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	103,586,942.47	ADJUSTMENTS	7,176,520.25
COVERED CHARGES	97,506,241.98	CONTRACTUAL ALLOW	65,445,927.08
NON-COVERD CHARGES	6,080,700.49	TOTAL MEDICAID LIAB	32,060,314.90
		LESS: COB	203,012.12
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	31,857,302.78

TOTAL NUMBER OF ADMISSIONS 1,695

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7,862		3	9,498,600.00		685,780.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		6,425.00
TOTAL ROUTINE	7,862		3	9,498,600.00		692,205.00
SPECIAL CARE SERVICES						
CCU	227		0	999,935.00		0.00
ICU	5,697		0	16,310,565.00		819,065.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	185		0	378,325.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		1,235	0.00		2,132,660.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	6,109		1,235	17,688,825.00		2,951,725.00
TOTAL ACCOMODATIONS	13,971		1,238	27,187,425.00		3,643,930.00

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,666,302.85	26,407.71	OTHER LAB	610,198.00	3,146.00
MED/SURG SUPPLY	5,019,860.48	193,872.32	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,857,522.06	183,048.00	EDUCATION & TRAINING	200.00	0.00
RADIOLOGY-DIAGNOSTIC	1,409,906.00	6,926.00	OTHER THERAPEUTIC SVC	0.00	2,170.00
CT SCAN	3,285,569.00	14,333.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,309,797.88	8,808.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	304,189.00	131.00	MRI SERVICES	2,114,850.00	6,282.00
IV THERAPY	13,912.00	181.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,005,430.00	40,073.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,659,517.00	155,627.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,855,333.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	388,371.00	10,305.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,143,212.00	10,041.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	648,656.00	1,188.00	DRUG-SPECIFIC/HOME IV	0.00	187,007.26
LABORATORY PATHOLOGIC	1,187,118.00	0.00	INJECTABLE DRUGS	13,464,011.84	81,206.34
RADIOLOGY THERAPEUTIC	168,798.00	18,488.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,250,414.30	7,558.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	454,532.25	2,212.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	416,366.00	92,697.00	PATIENT CONVENIENCE	0.00	1,158.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	137.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	7,368.00	0.00	IMPL DEV CHARGE PATIENTS	1,996,852.07	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	943,919.86
OTHER IMAGING SERVICE	264,609.00	272,764.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,814,641.50	29,049.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	92,957.00	89,165.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,737,900.00	6,104.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	922,628.00	0.00			
ORGAN ACQUISITION	1,220,251.75	41,197.00			
TREATMENT/OBSERV. RM	27,406.00	1,706.00			
			TOTAL ANCILLARY	70,318,816.98	2,436,770.49
			TOTAL ACCOMODATIONS	27,187,425.00	3,643,930.00
			TOTAL CHARGES	97,506,241.98	6,080,700.49

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013287006254	09/29/13 - 10/02/13	10/21/13	0.00	6,282.00	0.00	0.00	0.00
614	2213324016305	09/08/13 - 09/17/13	11/25/13	0.00	6,282.00	0.00	0.00	0.00
614	2013331069773	11/10/13 - 11/19/13	12/02/13	0.00	6,282.00	0.00	0.00	0.00
614	2013345057519	11/12/13 - 11/14/13	12/16/13	0.00	6,282.00	0.00	0.00	0.00
614	2013352048956	11/28/13 - 12/05/13	12/23/13	0.00	2,841.00	0.00	0.00	0.00
614	2013353066879	10/17/13 - 10/19/13	12/23/13	0.00	6,282.00	0.00	0.00	0.00
614	2014021025947	12/26/13 - 01/10/14	01/27/14	0.00	6,282.00	0.00	0.00	0.00
614	2014036070576	11/17/13 - 11/27/13	02/10/14	0.00	6,282.00	0.00	0.00	0.00
614	2014055010898	02/12/14 - 02/17/14	03/03/14	0.00	6,282.00	0.00	0.00	0.00
614	2014057007734	02/14/14 - 02/17/14	03/03/14	0.00	6,282.00	0.00	0.00	0.00
614	2214057003691	01/20/14 - 01/25/14	03/03/14	0.00	6,282.00	0.00	0.00	0.00
614	2014062003359	02/11/14 - 02/14/14	03/10/14	0.00	6,282.00	0.00	0.00	0.00
614	2214069001274	01/26/14 - 02/14/14	03/17/14	0.00	6,282.00	0.00	0.00	0.00
614	2014083031281	03/12/14 - 03/16/14	03/31/14	0.00	6,282.00	0.00	0.00	0.00
614	2014090001994	03/10/14 - 03/24/14	04/07/14	0.00	6,282.00	0.00	0.00	0.00
614	5214092000152	12/27/13 - 01/15/14	04/07/14	0.00	6,282.00	0.00	0.00	0.00
614	2014099027372	03/10/14 - 03/31/14	04/14/14	0.00	6,282.00	0.00	0.00	0.00
614	2014104002613	03/12/14 - 04/03/14	04/21/14	0.00	6,282.00	0.00	0.00	0.00
614	2014111001547	04/13/14 - 04/15/14	04/28/14	0.00	6,282.00	0.00	0.00	0.00
614	2014115037711	02/02/14 - 03/06/14	04/28/14	0.00	6,282.00	0.00	0.00	0.00
614	5214120000016	11/05/13 - 11/26/13	05/05/14	0.00	6,282.00	0.00	0.00	0.00
614	2014127025288	11/16/13 - 11/27/13	05/12/14	0.00	6,282.00	0.00	0.00	0.00
614	5914128000064	04/02/14 - 04/09/14	05/12/14	0.00	2,841.00	0.00	0.00	0.00
614	2014129045805	04/21/14 - 05/02/14	05/12/14	0.00	12,564.00	0.00	0.00	0.00
614	5914133000021	10/07/13 - 10/16/13	05/19/14	0.00	6,273.00	0.00	0.00	0.00
614	2214133000369	04/01/14 - 04/11/14	05/19/14	0.00	6,282.00	0.00	0.00	0.00
614	5214135000203	02/16/14 - 02/28/14	05/19/14	0.00	6,282.00	0.00	0.00	0.00
614	2014136023752	05/05/14 - 05/09/14	05/19/14	0.00	6,282.00	0.00	0.00	0.00
614	2014139002420	03/31/14 - 04/09/14	05/26/14	0.00	6,282.00	0.00	0.00	0.00
614	2214139000437	04/16/14 - 04/23/14	05/26/14	0.00	6,282.00	0.00	0.00	0.00
614	9114107003578	10/07/13 - 10/24/13	05/26/14	0.00	6,282.00	0.00	3,166.15	0.00
614	2014143037452	05/03/14 - 05/14/14	05/26/14	0.00	12,564.00	0.00	0.00	0.00
614	2014147034988	05/15/14 - 05/20/14	06/02/14	0.00	6,273.00	0.00	0.00	0.00
614	2014153002055	05/10/14 - 05/16/14	06/09/14	0.00	6,282.00	0.00	0.00	0.00
614	2014153002129	05/19/14 - 05/23/14	06/09/14	0.00	6,282.00	0.00	0.00	0.00
614	2014155022424	03/25/14 - 04/04/14	06/09/14	0.00	12,564.00	0.00	0.00	0.00
614	2014155048041	03/20/14 - 03/30/14	06/09/14	0.00	2,661.00	0.00	0.00	0.00
615	2014155048041	03/20/14 - 03/30/14	06/09/14	0.00	5,614.00	0.00	0.00	0.00
614	2014157022383	03/20/14 - 04/02/14	06/09/14	0.00	12,564.00	0.00	0.00	0.00
614	2214157015464	05/17/14 - 05/24/14	06/09/14	0.00	6,282.00	0.00	0.00	0.00
614	2014163019010	06/02/14 - 06/05/14	06/16/14	0.00	2,135.00	0.00	0.00	0.00
614	2014168016492	06/06/14 - 06/09/14	06/23/14	0.00	6,244.00	0.00	0.00	0.00

SUMMARY TYPE I
INPATIENT PAID CLAIMS

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1364 CLIFTON RD NE DEPT RM
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CLM#	CLM#	DATE	DATE	DATE	AMOUNT	AMOUNT	AMOUNT	AMOUNT
615	2014168016492	06/06/14	-	06/09/14	0.00	11,228.00	0.00	0.00
614	2014170023701	05/23/14	-	06/11/14	0.00	12,564.00	0.00	0.00
614	5214171000131	02/08/14	-	03/17/14	0.00	6,282.00	0.00	0.00
614	2014174001625	05/03/14	-	05/23/14	0.00	12,564.00	0.00	0.00
614	2014176014781	06/13/14	-	06/18/14	0.00	6,273.00	0.00	0.00
615	2014176014781	06/13/14	-	06/18/14	0.00	5,614.00	0.00	0.00
614	2014177023949	06/03/14	-	06/19/14	0.00	6,282.00	0.00	0.00
615	2014177023949	06/03/14	-	06/19/14	0.00	5,614.00	0.00	0.00
614	2214178009997	04/01/14	-	04/02/14	0.00	12,564.00	0.00	0.00
614	9114177003156	10/09/13	-	10/13/13	0.00	12,564.00	0.00	2,141.13
614	2014184025386	06/25/14	-	06/26/14	0.00	6,282.00	0.00	0.00
618	2014188001442	06/19/14	-	06/29/14	0.00	2,768.00	0.00	0.00
615	9114174012028	09/14/13	-	09/24/13	0.00	8,485.00	0.00	4,140.62
614	2214189010896	09/30/13	-	10/09/13	0.00	6,282.00	0.00	0.00
614	2014191022472	06/25/14	-	07/03/14	0.00	6,282.00	0.00	0.00
614	2014191022566	05/01/14	-	05/08/14	0.00	6,282.00	0.00	0.00
614	2214191014747	06/02/14	-	06/12/14	0.00	12,564.00	0.00	0.00
614	2014192022003	06/03/14	-	06/17/14	0.00	2,135.00	0.00	0.00
615	2014196017001	07/01/14	-	07/08/14	0.00	11,228.00	0.00	0.00
614	2014198021449	06/16/14	-	07/11/14	0.00	6,282.00	0.00	0.00
614	2214198013898	05/30/14	-	06/18/14	0.00	6,282.00	0.00	0.00
614	2214203002919	06/23/14	-	06/24/14	0.00	12,564.00	0.00	0.00
614	2014210011363	07/09/14	-	07/12/14	0.00	12,564.00	0.00	0.00
614	5914212000067	05/25/14	-	06/13/14	0.00	1,500.00	0.00	0.00
615	2014213027768	07/18/14	-	07/25/14	0.00	11,228.00	0.00	0.00
614	2214213012346	06/02/14	-	07/18/14	0.00	11,809.00	0.00	0.00
614	2014217020961	07/23/14	-	07/30/14	0.00	2,768.00	0.00	0.00
614	5214220000092	01/17/14	-	04/07/14	0.00	2,841.00	0.00	0.00
614	2214227014165	07/21/14	-	07/26/14	0.00	6,282.00	0.00	0.00
615	2014230001189	08/06/14	-	08/09/14	0.00	11,228.00	0.00	0.00
614	2014233028032	08/12/14	-	08/14/14	0.00	12,564.00	0.00	0.00
615	2014234038388	05/23/14	-	05/31/14	0.00	11,228.00	0.00	0.00
615	2214234017513	12/05/13	-	12/12/13	0.00	5,614.00	0.00	0.00
614	2014237002587	07/11/14	-	08/07/14	0.00	2,768.00	0.00	0.00
614	5214237000070	05/01/14	-	06/19/14	0.00	6,282.00	0.00	0.00
614	2014238009564	07/31/14	-	08/11/14	0.00	6,282.00	0.00	0.00
614	2214239002479	07/12/14	-	07/28/14	0.00	2,768.00	0.00	0.00
615	2014240027346	07/31/14	-	08/10/14	0.00	2,871.00	0.00	0.00
615	2014242027270	08/19/14	-	08/24/14	0.00	11,228.00	0.00	0.00
614	2014247033803	08/21/14	-	08/23/14	0.00	12,564.00	0.00	0.00
614	2014247033815	08/22/14	-	08/27/14	0.00	2,768.00	0.00	0.00
614	2014249025452	08/26/14	-	08/31/14	0.00	12,564.00	0.00	0.00
614	2214253007244	06/23/14	-	07/30/14	0.00	6,273.00	0.00	0.00
614	5214255002305	09/05/13	-	01/27/14	0.00	6,282.00	0.00	0.00
615	2014259010234	08/28/14	-	09/10/14	0.00	5,742.00	0.00	0.00
614	2214259005693	11/26/13	-	11/29/13	0.00	6,282.00	0.00	0.00

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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CLAIM NO	PATIENT ID	START DATE	END DATE	PROVIDER	CHARGE	PAYMENT	ADJUST	NET AMT
614	2214261000864	06/20/14	07/30/14	09/22/14	0.00	12,564.00	0.00	0.00
614	2214268019103	06/04/14	06/10/14	09/29/14	0.00	2,832.00	0.00	0.00
614	2214268020192	07/01/14	07/18/14	09/29/14	0.00	6,282.00	0.00	0.00
614	5914269000082	04/17/14	05/02/14	09/29/14	0.00	6,282.00	0.00	0.00
24	9114266001860	04/23/14	04/23/14	10/06/14	0.00	0.00	2,635.19	0.00
614	5214275000006	01/11/14	03/28/14	10/06/14	0.00	6,282.00	0.00	0.00
614	2214276005894	08/11/14	08/28/14	10/06/14	0.00	12,564.00	0.00	0.00
618	2014281031185	08/02/14	08/29/14	10/13/14	0.00	6,141.00	0.00	0.00
614	5214281004420	09/27/13	10/30/13	10/13/14	0.00	6,282.00	0.00	0.00
614	2014282024363	08/27/14	09/30/14	10/13/14	0.00	13,194.00	0.00	0.00
614	2014282024391	05/05/14	05/08/14	10/13/14	0.00	12,564.00	0.00	0.00
615	2014282024426	06/21/14	07/15/14	10/13/14	0.00	11,228.00	0.00	0.00
614	2014282024438	04/03/14	04/07/14	10/13/14	0.00	6,282.00	0.00	0.00
614	9114281003008	08/05/14	08/19/14	10/20/14	0.00	6,282.00	0.00	2,304.23
615	2214296006264	04/22/14	05/09/14	10/27/14	0.00	2,871.00	0.00	0.00
614	2214297016480	03/15/14	03/19/14	10/27/14	0.00	2,135.00	0.00	0.00
615	2214297019306	01/05/14	02/08/14	10/27/14	0.00	11,228.00	0.00	0.00
614	5214297003937	04/04/14	05/22/14	11/03/14	0.00	6,282.00	0.00	0.00
614	2314302000047	07/27/14	07/31/14	11/24/14	0.00	12,564.00	0.00	0.00
614	2014303034960	08/02/14	08/08/14	11/03/14	0.00	12,564.00	0.00	0.00
614	9114300009652	08/03/14	08/17/14	11/10/14	0.00	12,546.00	0.00	8,302.60
615	9114300009652	08/03/14	08/17/14	11/10/14	0.00	44,389.86	0.00	8,302.60
614	9114301001694	09/05/13	09/25/13	11/10/14	0.00	6,282.00	0.00	6,541.46
614	5214310000138	04/29/14	08/02/14	11/10/14	0.00	6,282.00	0.00	0.00
618	5214310000138	04/29/14	08/02/14	11/10/14	0.00	5,536.00	0.00	0.00
614	2014311028256	05/23/14	05/29/14	11/10/14	0.00	2,768.00	0.00	0.00
615	2014316042647	01/14/14	01/17/14	11/17/14	0.00	16,842.00	0.00	0.00
614	2014326026975	06/07/14	07/16/14	12/01/14	0.00	2,135.00	0.00	0.00
614	5214338000037	08/15/14	10/29/14	12/08/14	0.00	12,564.00	0.00	0.00
614	2015021011838	01/09/14	01/14/14	01/26/15	0.00	6,282.00	0.00	0.00
615	2215035016225	08/07/14	09/05/14	02/09/15	0.00	14,099.00	0.00	0.00
614	2015049010747	08/05/14	08/22/14	03/09/15	0.00	6,282.00	0.00	0.00
618	2215051011897	05/03/14	07/18/14	02/23/15	0.00	2,768.00	0.00	0.00
615	2315078000460	05/10/14	07/18/14	04/13/15	0.00	2,871.00	0.00	0.00
614	2015101022729	05/25/14	06/04/14	04/20/15	0.00	2,135.00	0.00	0.00
614	2015106033397	08/22/14	09/05/14	04/20/15	0.00	1,500.00	0.00	0.00
614	2015106033450	10/10/13	10/11/13	04/20/15	0.00	2,768.00	0.00	0.00
614	2015107029409	06/18/14	06/25/14	04/20/15	0.00	6,282.00	0.00	0.00
614	2315112000049	04/12/14	04/16/14	05/04/15	0.00	6,282.00	0.00	1,580.72

TOTAL 0.00 943,919.86 0.00 39,114.70 0.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:09:16
 Page: 6

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

EMORY UNIV HOSPPT FINANCIALSERV
 1364 CLIFTON RD NE DEPT RM
 ATLANTA,GA 30322-1059

PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
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 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,076,232.56	ADJUSTMENTS	0.00
COVERED CHARGES	2,022,530.96	CONTRACTUAL ALLOW	733,942.16
NON-COVERD CHARGES	53,701.60	TOTAL MEDICAID LIAB	1,288,588.80
		LESS: COB	1,288,588.80
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 30

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	143		0	174,460.00		9,295.00
ROUTINE NURSERY	0		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	174,460.00		9,295.00
SPECIAL CARE SERVICES						
CCU	1		0	4,405.00		0.00
ICU	110		0	328,390.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	111		0	332,795.00		0.00
TOTAL ACCOMODATIONS	254		0	507,255.00		9,295.00

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PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	83,188.08	0.00	OTHER LAB	6,213.00	0.00
MED/SURG SUPPLY	110,952.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	181,475.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,432.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	64,837.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	13,537.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,930.00	0.00	MRI SERVICES	43,026.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	300,340.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	54,383.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	56,746.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	8,307.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,486.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,857.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	31,269.60
LABORATORY PATHOLOGIC	13,669.00	0.00	INJECTABLE DRUGS	172,409.48	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,524.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,530.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,160.00	PATIENT CONVENIENCE	0.00	55.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	189,531.40	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	6,282.00
OTHER IMAGING SERVICE	3,264.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	16,577.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,382.00	3,640.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	43,829.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	85,696.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	155.00	0.00			
			TOTAL ANCILLARY	1,515,275.96	44,406.60
			TOTAL ACCOMODATIONS	507,255.00	9,295.00
			TOTAL CHARGES	2,022,530.96	53,701.60

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013339033400	10/24/13 - 10/27/13	12/09/13	0.00	6,282.00	0.00	14,852.38	0.00
TOTAL				0.00	6,282.00	0.00	14,852.38	0.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	28,181,437.96	ADJUSTMENTS	981,166.29
COVERED CHARGES	19,957,879.91	CONTRACTUAL ALLOW	15,432,160.39
NON-COVERD CHARGES	8,223,558.05	TOTAL MEDICAID LIAB	4,525,719.52
		LESS: COB	20,152.44
		LESS: COPAYMENT	15,265.66
		REIMBURSEMENT	4,490,301.42
		ALL OTHER	3,615,217.70
		FEE SCHEDULE-LAB	765,405.43
		INJECTABLE DRUGS	109,678.29
		TOTAL NUMBER OF CLAIMS	12,547

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	193,885.80	385,191.15	OTHER LAB	166,712.00	3,250.00
MED/SURG SUPPLY	646,795.00	332,731.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	753.00	EDUCATION & TRAINING	0.00	1,500.00
RADIOLOGY-DIAGNOSTIC	533,421.00	126,972.00	OTHER THERAPEUTIC SVC	38,970.00	233,816.00
CT SCAN	2,109,310.00	832,203.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	101,218.00	23,045.03	FEE SCHEDULE LAB	4,199,470.18	1,295,512.61
EKG/ECG	96,416.00	1,965.00	MRI SERVICES	4,930,514.00	769,394.00
IV THERAPY	1,243.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,729,807.00	503,043.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	43,834.00	9,673.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	288,964.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	121,860.00	78,025.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,279,477.00	47,476.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	235,018.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	468,059.93	1,120,228.95
RADIOLOGY THERAPEUTIC	840.00	1,338.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	85,946.00	24,898.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	54,395.00	18,075.04	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	81,486.00	PATIENT CONVENIENCE	0.00	65.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	57.00	3,671.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	64,114.00	385,100.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	436,808.00
OTHER IMAGING SERVICE	874,902.00	499,722.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	331,335.00	4,276.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	304,246.00	239,082.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	754,442.00	731,641.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	40,746.00	546.00			
ORGAN ACQUISITION	0.00	23,054.25			
TREATMENT/OBSERV. RM	261,882.00	9,017.00			
			TOTAL ANCILLARY	19,957,879.91	8,223,558.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	19,957,879.91	8,223,558.05

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013263077892	09/13/13 - 09/13/13	09/23/13	0.00	215.00	0.00	0.00	0.00
614	2013315016625	11/05/13 - 11/05/13	11/18/13	0.00	6,282.00	0.00	0.00	0.00
614	2013316055995	11/02/13 - 11/02/13	11/18/13	0.00	6,282.00	0.00	0.00	0.00
614	2013323032533	11/11/13 - 11/11/13	11/25/13	0.00	6,282.00	0.00	0.00	0.00
614	2013329021720	11/18/13 - 11/18/13	12/02/13	0.00	6,282.00	0.00	0.00	0.00
614	2013331071293	11/21/13 - 11/21/13	12/02/13	0.00	6,282.00	0.00	0.00	0.00
614	2013331071360	11/21/13 - 11/21/13	12/02/13	0.00	6,282.00	0.00	0.00	0.00
614	2013337045225	11/15/13 - 11/15/13	12/09/13	0.00	6,282.00	0.00	0.00	0.00
614	2013338057841	11/26/13 - 11/26/13	12/09/13	0.00	6,282.00	0.00	0.00	0.00
614	2013338057904	11/25/13 - 11/25/13	12/09/13	0.00	6,282.00	0.00	0.00	0.00
614	2013340057350	11/21/13 - 11/21/13	12/09/13	0.00	6,282.00	0.00	0.00	0.00
614	2013345058398	11/26/13 - 11/26/13	12/16/13	0.00	6,282.00	0.00	0.00	0.00
614	2013352049106	09/13/13 - 09/13/13	12/23/13	0.00	6,282.00	0.00	0.00	0.00
614	2013357023123	11/27/13 - 11/27/13	12/30/13	0.00	6,282.00	0.00	0.00	0.00
615	2014037022849	01/22/14 - 01/22/14	02/10/14	0.00	5,614.00	0.00	0.00	0.00
614	2014072007741	03/05/14 - 03/05/14	03/17/14	0.00	215.00	0.00	0.00	0.00
614	2014099032658	04/03/14 - 04/03/14	04/14/14	0.00	6,282.00	0.00	0.00	0.00
614	2014100006286	04/03/14 - 04/03/14	04/14/14	0.00	215.00	0.00	0.00	0.00
614	2014105042411	04/08/14 - 04/08/14	04/21/14	0.00	6,282.00	0.00	0.00	0.00
614	2214106005871	11/05/13 - 11/05/13	04/21/14	0.00	6,282.00	0.00	0.00	0.00
614	2014107025703	03/12/14 - 03/12/14	04/21/14	0.00	6,282.00	0.00	0.00	0.00
614	2014108028538	04/02/14 - 04/02/14	04/21/14	0.00	6,282.00	0.00	0.00	0.00
614	2014115037942	04/14/14 - 04/14/14	04/28/14	0.00	6,282.00	0.00	0.00	0.00
614	2014118001993	11/12/13 - 11/12/13	05/05/14	0.00	6,282.00	0.00	0.00	0.00
614	2014122030410	04/07/14 - 04/07/14	05/05/14	0.00	6,282.00	0.00	0.00	0.00
614	2014126021847	04/29/14 - 04/29/14	05/12/14	0.00	6,282.00	0.00	0.00	0.00
614	2014128056276	04/28/14 - 04/28/14	05/12/14	0.00	6,282.00	0.00	0.00	0.00
614	2014132001969	05/02/14 - 05/02/14	05/19/14	0.00	6,282.00	0.00	0.00	0.00
614	2014132002029	04/29/14 - 04/29/14	05/19/14	0.00	6,282.00	0.00	0.00	0.00
614	2014132002033	04/24/14 - 04/24/14	05/19/14	0.00	6,282.00	0.00	0.00	0.00
614	2014135023681	04/07/14 - 04/07/14	05/19/14	0.00	6,282.00	0.00	0.00	0.00
614	2014139003821	04/25/14 - 04/25/14	05/26/14	0.00	6,282.00	0.00	0.00	0.00
614	2214139004602	02/25/14 - 02/25/14	05/26/14	0.00	215.00	0.00	0.00	0.00
614	2014146000671	04/24/14 - 04/24/14	06/02/14	0.00	2,135.00	0.00	0.00	0.00
618	2014146000671	04/24/14 - 04/24/14	06/02/14	0.00	2,768.00	0.00	0.00	0.00
614	2214153003976	04/28/14 - 04/28/14	06/09/14	0.00	6,282.00	0.00	0.00	0.00
614	2014155023560	04/02/14 - 04/02/14	06/09/14	0.00	6,282.00	0.00	0.00	0.00
614	2014155023795	04/25/14 - 04/25/14	06/09/14	0.00	6,282.00	0.00	0.00	0.00
614	2014160001254	09/10/13 - 09/10/13	06/16/14	0.00	6,282.00	0.00	0.00	0.00
614	2014162072812	02/03/14 - 02/03/14	06/16/14	0.00	6,282.00	0.00	0.00	0.00
618	2014164021613	06/05/14 - 06/05/14	06/16/14	0.00	2,768.00	0.00	0.00	0.00
618	2014164021613	06/05/14 - 06/05/14	06/16/14	0.00	2,768.00	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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CLM#	CLM#	DATE	DATE	DATE	AMOUNT	DATE	DATE	DATE	DATE
618	2014164021613	06/05/14	-	06/05/14	0.00	2,768.00	0.00	0.00	0.00
618	5914167000710	05/22/14	-	05/22/14	0.00	2,768.00	0.00	0.00	0.00
618	5914167000710	05/22/14	-	05/22/14	0.00	2,768.00	0.00	0.00	0.00
614	5914174000033	01/13/14	-	01/13/14	0.00	6,282.00	0.00	0.00	0.00
614	2014178024003	06/19/14	-	06/19/14	0.00	5,434.00	0.00	0.00	0.00
614	2014178024240	11/07/13	-	11/07/13	0.00	6,282.00	0.00	0.00	0.00
614	2014178024240	11/07/13	-	11/07/13	0.00	6,282.00	0.00	0.00	0.00
615	2014192022103	07/02/14	-	07/02/14	0.00	5,614.00	0.00	0.00	0.00
615	2014192022103	07/02/14	-	07/02/14	0.00	5,614.00	0.00	0.00	0.00
618	2014196017657	07/08/14	-	07/08/14	0.00	2,768.00	0.00	0.00	0.00
618	2014196017657	07/08/14	-	07/08/14	0.00	2,768.00	0.00	0.00	0.00
614	2014198022928	07/03/14	-	07/03/14	0.00	6,273.00	0.00	0.00	0.00
614	2014202003137	07/09/14	-	07/09/14	0.00	2,768.00	0.00	0.00	0.00
614	2214203011891	06/03/14	-	06/03/14	0.00	6,282.00	0.00	0.00	0.00
614	2014206020596	07/18/14	-	07/18/14	0.00	3,392.00	0.00	0.00	0.00
618	5914206001503	06/19/14	-	06/19/14	0.00	2,768.00	0.00	0.00	0.00
618	5914218000943	06/26/14	-	06/26/14	0.00	2,768.00	0.00	0.00	0.00
8502	5914219000485	03/11/14	-	03/11/14	0.00	28.00	0.00	0.00	0.00
614	2014226026720	08/06/14	-	08/06/14	0.00	6,282.00	0.00	0.00	0.00
3025	5914226001067	05/14/14	-	05/14/14	0.00	50.00	0.00	0.00	0.00
615	2014230049386	08/10/14	-	08/10/14	0.00	5,614.00	0.00	0.00	0.00
615	2014230049386	08/10/14	-	08/10/14	0.00	5,614.00	0.00	0.00	0.00
614	2014231020119	08/06/14	-	08/06/14	0.00	6,282.00	0.00	0.00	0.00
614	2014231020119	08/06/14	-	08/06/14	0.00	6,282.00	0.00	0.00	0.00
618	2014231020119	08/06/14	-	08/06/14	0.00	2,768.00	0.00	0.00	0.00
618	2014231020119	08/06/14	-	08/06/14	0.00	2,768.00	0.00	0.00	0.00
614	2014234038472	08/14/14	-	08/14/14	0.00	6,282.00	0.00	0.00	0.00
614	2014234038489	07/23/14	-	07/23/14	0.00	2,135.00	0.00	0.00	0.00
618	2014234038489	07/23/14	-	07/23/14	0.00	2,768.00	0.00	0.00	0.00
618	5914234000743	05/01/14	-	05/01/14	0.00	2,768.00	0.00	0.00	0.00
618	5914234000743	05/01/14	-	05/01/14	0.00	2,768.00	0.00	0.00	0.00
618	5914234000782	06/27/14	-	06/27/14	0.00	2,768.00	0.00	0.00	0.00
618	5914234000782	06/27/14	-	06/27/14	0.00	2,768.00	0.00	0.00	0.00
618	5914234000897	06/19/14	-	06/19/14	0.00	2,768.00	0.00	0.00	0.00
618	5914234000897	06/19/14	-	06/19/14	0.00	2,768.00	0.00	0.00	0.00
618	5914234000947	05/14/14	-	05/14/14	0.00	2,768.00	0.00	0.00	0.00
618	5914234000947	05/14/14	-	05/14/14	0.00	2,768.00	0.00	0.00	0.00
618	5914234000966	06/10/14	-	06/10/14	0.00	2,768.00	0.00	0.00	0.00
618	5914234000966	06/10/14	-	06/10/14	0.00	2,768.00	0.00	0.00	0.00
615	2014239032075	08/16/14	-	08/16/14	0.00	5,614.00	0.00	0.00	0.00
615	2014239032075	08/16/14	-	08/16/14	0.00	5,614.00	0.00	0.00	0.00
614	2014239032121	08/15/14	-	08/15/14	0.00	6,282.00	0.00	0.00	0.00
614	2014246006978	08/26/14	-	08/26/14	0.00	6,282.00	0.00	0.00	0.00
615	2014246007082	08/20/14	-	08/20/14	0.00	2,871.00	0.00	0.00	0.00
614	2014247033925	08/19/14	-	08/19/14	0.00	6,282.00	0.00	0.00	0.00
615	2214273002898	07/28/14	-	07/28/14	0.00	2,871.00	0.00	0.00	0.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

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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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

618	5914295002784	07/01/14 - 07/01/14	10/27/14	0.00	2,768.00	0.00	0.00	0.00
618	5914295002784	07/01/14 - 07/01/14	10/27/14	0.00	2,768.00	0.00	0.00	0.00
618	5914296000633	07/29/14 - 07/29/14	10/27/14	0.00	2,768.00	0.00	0.00	0.00
618	5914296000633	07/29/14 - 07/29/14	10/27/14	0.00	2,768.00	0.00	0.00	0.00
615	2214344004059	07/05/14 - 07/05/14	01/26/15	0.00	5,614.00	0.00	0.00	0.00
615	2214344004059	07/05/14 - 07/05/14	01/26/15	0.00	5,614.00	0.00	0.00	0.00
31	2214353017176	06/27/14 - 06/27/14	12/22/14	0.00	39.00	0.00	0.00	0.00
614	2015036018248	08/05/14 - 08/05/14	02/09/15	0.00	6,282.00	0.00	0.00	0.00
TOTAL				0.00	436,808.00	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	941,209.06	ADJUSTMENTS	0.00
COVERED CHARGES	412,490.57	CONTRACTUAL ALLOW	51,891.59
NON-COVERD CHARGES	528,718.49	TOTAL MEDICAID LIAB	360,598.98
		LESS: COB	360,149.65
		LESS: COPAYMENT	449.33
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 190

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,515.94	12,705.71	OTHER LAB	790.00	0.00
MED/SURG SUPPLY	23,697.00	8,082.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	50.00
RADIOLOGY-DIAGNOSTIC	20,148.00	4,550.00	OTHER THERAPEUTIC SVC	0.00	12,990.00
CT SCAN	43,544.00	33,765.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	3,112.00	FEE SCHEDULE LAB	87,831.00	34,692.10
EKG/ECG	2,882.00	0.00	MRI SERVICES	48,163.00	57,432.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	39,754.00	73,015.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	498.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	24,594.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	4,483.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	43,025.00	2,071.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,811.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,505.63	10,585.18
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	4,639.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	808.00	856.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	325.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	8,982.00	40,901.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	80,303.00
OTHER IMAGING SERVICE	4,950.00	43,526.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,624.00	5,470.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	14,511.00	90,714.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	636.00	0.00			
ORGAN ACQUISITION	0.00	4,037.50			
TREATMENT/OBSERV. RM	10,221.00	414.00			
			TOTAL ANCILLARY	412,490.57	528,718.49
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	412,490.57	528,718.49

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014129045823	03/14/14 - 03/14/14	05/12/14	0.00	6,282.00	0.00	7,435.00	0.00
614	2014129045823	03/14/14 - 03/14/14	05/12/14	0.00	6,282.00	0.00	7,435.00	0.00
614	2014162060655	05/08/14 - 05/08/14	06/16/14	0.00	6,282.00	0.00	1,120.50	0.00
614	2014168017442	05/20/14 - 05/20/14	06/23/14	0.00	6,282.00	0.00	813.74	0.00
614	2014183019231	06/10/14 - 06/10/14	07/07/14	0.00	6,273.00	0.00	4,852.82	0.00
614	2014206020367	06/23/14 - 06/23/14	07/28/14	0.00	6,282.00	0.00	928.54	0.00
615	2014209003535	06/02/14 - 06/02/14	08/04/14	0.00	5,614.00	0.00	11,568.10	0.00
615	2014209003535	06/02/14 - 06/02/14	08/04/14	0.00	5,614.00	0.00	11,568.10	0.00
614	2014246007020	07/29/14 - 07/29/14	09/08/14	0.00	6,282.00	0.00	808.00	0.00
614	2014302011099	07/23/14 - 07/23/14	11/03/14	0.00	12,546.00	0.00	2,074.85	0.00
614	2014325029710	03/06/14 - 03/06/14	11/24/14	0.00	6,282.00	0.00	3,783.43	0.00
614	2015129032556	07/30/14 - 07/30/14	05/18/15	0.00	6,282.00	0.00	2,992.96	0.00
TOTAL				0.00	80,303.00	0.00	55,381.04	0.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	278,647.06	ADJUSTMENTS	532.40
COVERED CHARGES	222,696.99	CONTRACTUAL ALLOW	213,858.49
NON-COVERD CHARGES	55,950.07	TOTAL MEDICAID LIAB	8,838.50
		LESS: COB	0.00
		LESS: COPAYMENT	429.00
		REIMBURSEMENT	8,409.50
		TOTAL NUMBER OF CLAIMS	159

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	801.23	1,138.55	OTHER LAB	9,239.00	0.00
MED/SURG SUPPLY	795.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,994.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,353.00	18,573.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	38,329.00	9,523.00
EKG/ECG	3,406.00	131.00	MRI SERVICES	20,583.00	15,055.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	908.00	453.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	101,709.00	3,217.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,075.76	6,416.52
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,229.00	1,035.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,275.00	408.00			
			TOTAL ANCILLARY	222,696.99	55,950.07
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	222,696.99	55,950.07

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,757.31	ADJUSTMENTS	0.00
COVERED CHARGES	14,003.86	CONTRACTUAL ALLOW	8,613.82
NON-COVERD CHARGES	1,753.45	TOTAL MEDICAID LIAB	5,390.04
		LESS: COB	5,372.04
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	7

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35.00	25.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	91.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	908.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,994.00	354.00
EKG/ECG	262.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,788.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	355.86	1,374.45
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,570.00	0.00			
			TOTAL ANCILLARY	14,003.86	1,753.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,003.86	1,753.45

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,142,127.30	ADJUSTMENTS	110,093.17
COVERED CHARGES	2,619,844.18	CONTRACTUAL ALLOW	2,159,317.59
NON-COVERD CHARGES	522,283.12	TOTAL MEDICAID LIAB	460,526.59
		LESS: COB	0.00
		LESS: COPAYMENT	275.65
		REIMBURSEMENT	460,250.94
		TOTAL NUMBER OF CLAIMS	69

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,379.40	3,480.59	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	94,135.27	140,929.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	400.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	567,972.00	41,926.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,068.00	613.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	524.00	FEE SCHEDULE LAB	18,143.00	2,889.00
EKG/ECG	524.00	0.00	MRI SERVICES	25,090.00	6,141.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,043,097.00	118,942.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,084.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	82,869.00	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	31,252.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	42,178.29	67,681.53
RADIOLOGY THERAPEUTIC	9,955.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	597,060.22	123,792.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	6,282.00
OTHER IMAGING SERVICE	440.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	30,791.00	498.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	48,651.00	3,780.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	155.00	0.00			
			TOTAL ANCILLARY	2,619,844.18	517,878.12
			TOTAL ACCOMODATIONS	0.00	4,405.00
			TOTAL CHARGES	2,619,844.18	522,283.12

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013281037331	09/17/13 - 09/17/13	10/14/13	0.00	6,282.00	0.00	0.00	0.00
TOTAL				0.00	6,282.00	0.00	0.00	0.00

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	135,850.81	ADJUSTMENTS	0.00
COVERED CHARGES	108,478.98	CONTRACTUAL ALLOW	25,657.13
NON-COVERD CHARGES	27,371.83	TOTAL MEDICAID LIAB	82,821.85
		LESS: COB	82,809.85
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	770.11	631.56	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,938.00	125.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	174.00	0.00
EKG/ECG	131.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	24,115.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,307.00	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	3,139.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	326.87	215.27
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	93,693.00	2,285.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	108,478.98	27,371.83
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	108,478.98	27,371.83

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

MEDICAL COLLEGE OF GA HOSPITALS AND
 1120 15TH ST
 AUGUSTA,GA 30912-0004

PROVIDER NUMBER 000000723A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	130,593,518.03	ADJUSTMENTS	12,372,733.41
COVERED CHARGES	126,284,970.98	CONTRACTUAL ALLOW	89,114,241.91
NON-COVERD CHARGES	4,308,547.05	TOTAL MEDICAID LIAB	37,170,729.07
		LESS: COB	239,628.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	36,931,100.98

TOTAL NUMBER OF ADMISSIONS 2,681

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	12,766		60	8,805,193.00		2,007,500.00
ROUTINE NURSERY	1,465		0	2,919,187.00		70,622.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		1.11
TOTAL ROUTINE	14,231		60	11,724,380.00		2,078,123.11
SPECIAL CARE SERVICES						
CCU	84		0	128,990.00		9,810.00
ICU	2,359		1	4,458,835.00		48,380.00
NICU	860		0	3,124,417.00		0.00
PED ICU	737		0	2,634,338.00		3,470.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	375		0	1,172,079.00		6,126.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	4,415		1	11,518,659.00		67,786.00
TOTAL ACCOMODATIONS	18,646		61	23,243,039.00		2,145,909.11

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

MEDICAL COLLEGE OF GA HOSPITALS AND
 1120 15TH ST
 AUGUSTA,GA 30912-0004

PROVIDER NUMBER
 000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,145,599.49	374,862.61	OTHER LAB	280,904.99	23,126.00
MED/SURG SUPPLY	11,294,475.24	232,095.76	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	16,991,050.90	585,136.21	EDUCATION & TRAINING	5,556.00	0.00
RADIOLOGY-DIAGNOSTIC	2,411,267.00	8,846.00	OTHER THERAPEUTIC SVC	0.00	85,812.00
CT SCAN	2,859,547.00	49,213.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	602,199.42	14,065.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	174,772.00	148.00	MRI SERVICES	821,321.00	11,606.00
IV THERAPY	493,247.00	19,254.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,619,635.00	88,813.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	382,898.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,845,959.00	51,380.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,053,221.00	29,240.00	AMBULANCE	0.00	0.00
GI SERVICES	382,863.00	3,152.00	CAST ROOM	317.00	0.00
EMERGENCY ROOM	2,121,859.00	2,749.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	731,006.00	2,076.00	DRUG-SPECIFIC/HOME IV	0.00	15,121.76
LABORATORY PATHOLOGIC	940,853.00	422.00	INJECTABLE DRUGS	6,116,703.94	120,392.60
RADIOLOGY THERAPEUTIC	272,578.00	628.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	252,598.19	9,469.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	190,759.38	3,775.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	279,298.00	68,669.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	234.43	19,468.00	TRAUMA RESPONSE	0.00	155,665.00
PSYCHIATRIC SERVICES	33,534.00	0.00	IMPL DEV CHARGE PATIENTS	9,185,397.00	44,869.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	465,688.00	23,985.00			
BLOOD	168,522.00	1,707.00			
BLOOD STORAGE & PRO.	1,332,649.00	76,489.00			
ONCOLOGY	518.00	0.00			
NUCLEAR MEDICINE	181,950.00	96.00			
AUDIOLOGY	1,196.00	0.00			
CARDIOLOGY	1,864,943.00	0.00			
AMBULATORY SURGERY	6,306.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,845,463.00	35,086.00			
ORGAN ACQUISITION	445,594.00	0.00			
TREATMENT/OBSERV. RM	239,449.00	5,221.00			
			TOTAL ANCILLARY	103,041,931.98	2,162,637.94
			TOTAL ACCOMODATIONS	23,243,039.00	2,145,909.11
			TOTAL CHARGES	126,284,970.98	4,308,547.05

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

MEDICAL COLLEGE OF GA HOSPITALS AND
 1120 15TH ST
 AUGUSTA,GA 30912-0004

PROVIDER NUMBER 000000723A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,444,362.71	ADJUSTMENTS	0.00
COVERED CHARGES	1,424,382.71	CONTRACTUAL ALLOW	631,111.93
NON-COVERD CHARGES	19,980.00	TOTAL MEDICAID LIAB	793,270.78
		LESS: COB	793,270.78
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 47

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	113		7	79,778.00		18,650.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	113		7	79,778.00		18,650.00
SPECIAL CARE SERVICES						
CCU	1		0	1,527.00		0.00
ICU	21		0	35,195.00		0.00
NICU	5		0	17,350.00		0.00
PED ICU	21		0	75,873.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	129,945.00		0.00
TOTAL ACCOMODATIONS	161		7	209,723.00		18,650.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

MEDICAL COLLEGE OF GA HOSPITALS AND
 1120 15TH ST
 AUGUSTA,GA 30912-0004

PROVIDER NUMBER
 000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	197,864.42	0.00	OTHER LAB	1,289.00	0.00
MED/SURG SUPPLY	124,323.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	144,907.00	0.00	EDUCATION & TRAINING	128.00	0.00
RADIOLOGY-DIAGNOSTIC	21,285.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,038.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,863.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,588.00	0.00	MRI SERVICES	6,605.00	0.00
IV THERAPY	4,666.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	138,931.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,404.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	83,011.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	70,165.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,815.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,518.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	8,132.00	0.00	INJECTABLE DRUGS	58,603.27	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	795.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,065.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	756.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	172,094.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,544.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,808.00	478.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,155.00	96.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,440.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	87,255.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,368.00	0.00			
			TOTAL ANCILLARY	1,214,659.71	1,330.00
			TOTAL ACCOMODATIONS	209,723.00	18,650.00
			TOTAL CHARGES	1,424,382.71	19,980.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

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MEDICAL COLLEGE OF GA HOSPITALS AND
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	56,785,233.82	ADJUSTMENTS	1,948,942.99
COVERED CHARGES	50,793,036.93	CONTRACTUAL ALLOW	39,386,858.48
NON-COVERD CHARGES	5,992,196.89	TOTAL MEDICAID LIAB	11,406,178.45
		LESS: COB	69,365.86
		LESS: COPAYMENT	57,647.64
		REIMBURSEMENT	11,279,164.95
		ALL OTHER	9,607,709.45
		FEE SCHEDULE-LAB	793,136.39
		INJECTABLE DRUGS	878,319.11

TOTAL NUMBER OF CLAIMS 37,154

MEDICAL COLLEGE OF GA HOSPITALS AND
 1120 15TH ST
 AUGUSTA,GA 30912-0004

PROVIDER NUMBER
 000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,781,581.30	88,086.17	OTHER LAB	742,232.00	35,938.50
MED/SURG SUPPLY	1,643,384.00	143,524.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,078.00	EDUCATION & TRAINING	1,024.00	5,908.00
RADIOLOGY-DIAGNOSTIC	1,717,196.00	22,453.00	OTHER THERAPEUTIC SVC	0.00	35,437.00
CT SCAN	2,793,285.00	145,813.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	42,868.00	34,440.04	FEE SCHEDULE LAB	8,334,225.90	1,618,551.55
EKG/ECG	228,961.00	2,624.00	MRI SERVICES	1,738,382.00	82,732.00
IV THERAPY	737,085.00	28,071.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,693,392.31	764,998.94	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	13,617.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	884,405.00	64,101.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,750,443.00	433.00	AMBULANCE	0.00	0.00
GI SERVICES	617,755.90	51,833.99	CAST ROOM	17,692.00	1,080.00
EMERGENCY ROOM	3,645,459.00	3,940.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,191,541.00	1,023.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,534,297.05	1,097,871.91
RADIOLOGY THERAPEUTIC	2,312,205.00	15,598.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	10,108.00	16,095.07	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	26,093.00	15,995.07	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	22,651.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,046,312.99	38,896.15	TRAUMA RESPONSE	0.00	130,257.00
PSYCHIATRIC SERVICES	98,061.00	19,795.00	IMPL DEV CHARGE PATIENTS	423,437.00	665,656.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,327.00
OTHER IMAGING SERVICE	1,187,869.30	84,203.00			
BLOOD	58,607.00	0.00			
BLOOD STORAGE & PRO.	306,313.00	20,295.00			
ONCOLOGY	39,780.00	4,970.00			
NUCLEAR MEDICINE	611,035.00	35,675.00			
AUDIOLOGY	14,728.00	3,092.00			
CARDIOLOGY	992,749.00	665,405.50			
AMBULATORY SURGERY	31,395.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	872,205.00	8,772.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	653,312.18	4,308.00			
			TOTAL ANCILLARY	50,793,036.93	5,982,928.89
			TOTAL ACCOMODATIONS	0.00	9,268.00
			TOTAL CHARGES	50,793,036.93	5,992,196.89

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

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MEDICAL COLLEGE OF GA HOSPITALS AND
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
308	5913346001145	10/03/13 - 10/03/13	12/16/13	0.00	97.00	0.00	0.00	0.00
10	5914115000078	11/06/13 - 11/06/13	04/28/14	0.00	127.00	0.00	0.00	0.00
3606	5914253001289	01/23/14 - 01/23/14	09/15/14	0.00	1,103.00	0.00	0.00	0.00
TOTAL				0.00	1,327.00	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL COLLEGE OF GA HOSPITALS AND
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,165,064.90	ADJUSTMENTS	0.00
COVERED CHARGES	872,926.22	CONTRACTUAL ALLOW	483,133.03
NON-COVERD CHARGES	292,138.68	TOTAL MEDICAID LIAB	389,793.19
		LESS: COB	389,119.71
		LESS: COPAYMENT	673.48
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 711

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL COLLEGE OF GA HOSPITALS AND
 1120 15TH ST
 AUGUSTA,GA 30912-0004

PROVIDER NUMBER
 000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	49,638.89	3,570.00	OTHER LAB	15,324.00	2,520.00
MED/SURG SUPPLY	34,803.00	6,653.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	137.00
RADIOLOGY-DIAGNOSTIC	25,119.00	1,189.00	OTHER THERAPEUTIC SVC	240.00	0.00
CT SCAN	8,244.00	27,913.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	626.00	3,525.00	FEE SCHEDULE LAB	130,273.00	29,200.13
EKG/ECG	5,310.00	138.00	MRI SERVICES	36,344.00	10,579.00
IV THERAPY	12,637.00	1,226.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	142,762.90	29,825.10	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,983.00	4,250.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	57,792.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,573.00	9,245.00	CAST ROOM	328.00	0.00
EMERGENCY ROOM	71,982.00	1,451.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	34,123.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	84,686.43	114,112.45
RADIOLOGY THERAPEUTIC	11,300.00	0.00	HOME HEALTH SERVICES	0.00	2,053.00
OCCUPATIONAL THERAPY	0.00	1,060.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	316.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	41,834.00	1,317.00	TRAUMA RESPONSE	0.00	3,677.00
PSYCHIATRIC SERVICES	704.00	370.00	IMPL DEV CHARGE PATIENTS	1,983.00	27,188.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,495.00	1,874.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,399.00	0.00			
ONCOLOGY	705.00	83.00			
NUCLEAR MEDICINE	6,985.00	8,586.00			
AUDIOLOGY	269.00	0.00			
CARDIOLOGY	13,844.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	54,437.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,182.00	81.00			
			TOTAL ANCILLARY	872,926.22	292,138.68
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	872,926.22	292,138.68

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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MEDICAL COLLEGE OF GA HOSPITALS AND
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,677,289.13	ADJUSTMENTS	755.00
COVERED CHARGES	1,621,981.71	CONTRACTUAL ALLOW	1,511,431.71
NON-COVERD CHARGES	55,307.42	TOTAL MEDICAID LIAB	110,550.00
		LESS: COB	81.99
		LESS: COPAYMENT	3,732.01
		REIMBURSEMENT	106,736.00
		TOTAL NUMBER OF CLAIMS	2,211

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL COLLEGE OF GA HOSPITALS AND
 1120 15TH ST
 AUGUSTA,GA 30912-0004

PROVIDER NUMBER
 000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	87,651.85	850.82	OTHER LAB	12,340.00	0.00
MED/SURG SUPPLY	19,301.00	289.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	97,231.00	1,054.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	91,146.00	5,088.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	910.00	FEE SCHEDULE LAB	196,609.40	37,957.00
EKG/ECG	10,464.00	148.00	MRI SERVICES	16,764.00	2,467.00
IV THERAPY	62,770.00	1,578.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,014.00	781.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	16,769.00	1,309.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,957.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	10,157.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	919,821.00	193.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,859.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,713.46	987.60
RADIOLOGY THERAPEUTIC	10,086.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	253.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,843.00	22.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,402.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,617.00	1,420.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	459.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,605.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	941.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,461.00	0.00			
			TOTAL ANCILLARY	1,621,981.71	55,307.42
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,621,981.71	55,307.42

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL COLLEGE OF GA HOSPITALS AND
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	44,139.48	ADJUSTMENTS	0.00
COVERED CHARGES	40,788.48	CONTRACTUAL ALLOW	26,959.71
NON-COVERD CHARGES	3,351.00	TOTAL MEDICAID LIAB	13,828.77
		LESS: COB	13,771.77
		LESS: COPAYMENT	57.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	36

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

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SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL COLLEGE OF GA HOSPITALS AND
 1120 15TH ST
 AUGUSTA,GA 30912-0004

PROVIDER NUMBER
 000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,939.48	0.00	OTHER LAB	372.00	0.00
MED/SURG SUPPLY	64.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,906.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,773.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,826.00	1,274.00
EKG/ECG	424.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,364.00	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	22,005.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	223.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	665.00	0.00			
			TOTAL ANCILLARY	40,788.48	3,351.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	40,788.48	3,351.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL COLLEGE OF GA HOSPITALS AND
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,497,403.51	ADJUSTMENTS	796,056.60
COVERED CHARGES	10,860,203.17	CONTRACTUAL ALLOW	9,415,208.86
NON-COVERD CHARGES	1,637,200.34	TOTAL MEDICAID LIAB	1,444,994.31
		LESS: COB	10,901.87
		LESS: COPAYMENT	1,545.00
		REIMBURSEMENT	1,432,547.44

TOTAL NUMBER OF CLAIMS 250

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL COLLEGE OF GA HOSPITALS AND
 1120 15TH ST
 AUGUSTA,GA 30912-0004

PROVIDER NUMBER
 000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,007,226.89	5,641.52	OTHER LAB	2,969.00	0.00
MED/SURG SUPPLY	957,245.00	90,827.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	94,292.00	13,065.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	44,135.00	5,589.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	517.00	3,458.00	FEE SCHEDULE LAB	177,894.35	85,214.40
EKG/ECG	5,916.00	0.00	MRI SERVICES	8,892.00	13,858.00
IV THERAPY	11,069.00	1,304.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,038,244.24	130,966.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	36,264.00	1,345.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	284,978.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,599.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	33,541.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	99,097.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,718,657.89	71,978.45
RADIOLOGY THERAPEUTIC	1,325,439.00	3,818.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,400.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	704.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	143,764.50	314.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,483,989.00	553,537.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,212.00	235.00			
BLOOD	4,552.00	0.00			
BLOOD STORAGE & PRO.	1,399.00	1,399.00			
ONCOLOGY	1,067.00	0.00			
NUCLEAR MEDICINE	14,993.00	0.00			
AUDIOLOGY	0.00	639.00			
CARDIOLOGY	1,264,820.30	650,907.20			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	41,764.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	39,666.00	0.00			
			TOTAL ANCILLARY	10,860,203.17	1,637,200.34
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,860,203.17	1,637,200.34

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL COLLEGE OF GA HOSPITALS AND
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	138,841.40	ADJUSTMENTS	0.00
COVERED CHARGES	112,972.16	CONTRACTUAL ALLOW	44,111.59
NON-COVERD CHARGES	25,869.24	TOTAL MEDICAID LIAB	68,860.57
		LESS: COB	68,857.57
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL COLLEGE OF GA HOSPITALS AND
 1120 15TH ST
 AUGUSTA,GA 30912-0004

PROVIDER NUMBER
 000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,123.16	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	22,194.00	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	5,488.00	3,222.00
EKG/ECG	138.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,554.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,657.00	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	1,334.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	822.24
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	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	49,331.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,153.00	21,825.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	112,972.16	25,869.24
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	112,972.16	25,869.24

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:13:15
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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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	657,566.50	ADJUSTMENTS	0.00
COVERED CHARGES	611,557.50	CONTRACTUAL ALLOW	334,335.55
NON-COVERD CHARGES	46,009.00	TOTAL MEDICAID LIAB	277,221.95
		LESS: COB	3,728.10
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	273,493.85

TOTAL NUMBER OF ADMISSIONS 44

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	115		0	105,455.00		27,265.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	115		0	105,455.00		27,265.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	19		0	29,925.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	19		0	29,925.00		0.00
TOTAL ACCOMODATIONS	134		0	135,380.00		27,265.00

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	79,782.50	0.00	OTHER LAB	3,947.00	0.00
MED/SURG SUPPLY	46,133.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	149,657.00	0.00	EDUCATION & TRAINING	711.00	0.00
RADIOLOGY-DIAGNOSTIC	18,327.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	27,669.00	4,778.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,237.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	405.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	20,203.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,835.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	38,460.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	70,064.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	710.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,218.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,580.00	8,232.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,121.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,358.00	2,494.00			
			TOTAL ANCILLARY	476,177.50	18,744.00
			TOTAL ACCOMODATIONS	135,380.00	27,265.00
			TOTAL CHARGES	611,557.50	46,009.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,469,319.55	ADJUSTMENTS	55,584.09
COVERED CHARGES	1,378,231.05	CONTRACTUAL ALLOW	1,101,248.41
NON-COVERD CHARGES	91,088.50	TOTAL MEDICAID LIAB	276,982.64
		LESS: COB	611.27
		LESS: COPAYMENT	1,419.00
		REIMBURSEMENT	274,952.37
		ALL OTHER	254,802.80
		FEE SCHEDULE-LAB	18,948.73
		INJECTABLE DRUGS	1,200.84
		TOTAL NUMBER OF CLAIMS	1,068

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,423.45	304.00	OTHER LAB	4,210.00	0.00
MED/SURG SUPPLY	40,819.00	258.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	105.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	95,806.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	243,326.00	13,632.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,059.00	315.00	FEE SCHEDULE LAB	259,436.60	50,437.50
EKG/ECG	18,244.00	189.00	MRI SERVICES	81,052.00	3,602.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	52,912.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	34,709.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	80,310.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	309,737.00	7,250.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	632.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	74.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18,132.00	9,073.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	347.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	284.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,296.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	79.00
OTHER IMAGING SERVICE	34,882.00	27.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,480.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,809.00	552.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,828.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	35,781.00	4,907.00			
			TOTAL ANCILLARY	1,378,231.05	91,088.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,378,231.05	91,088.50

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
30	2214002013647	12/27/13 - 12/27/13	01/06/14	0.00	79.00	0.00	0.00	0.00
TOTAL				0.00	79.00	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,093.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,003.00	CONTRACTUAL ALLOW	1,828.17
NON-COVERD CHARGES	90.00	TOTAL MEDICAID LIAB	1,174.83
		LESS: COB	1,153.83
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 9

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2.00	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	258.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	558.00	90.00
EKG/ECG	189.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	673.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,323.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,003.00	90.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,003.00	90.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	142,987.00	ADJUSTMENTS	323.64
COVERED CHARGES	130,904.00	CONTRACTUAL ALLOW	120,890.74
NON-COVERD CHARGES	12,083.00	TOTAL MEDICAID LIAB	10,013.26
		LESS: COB	6.56
		LESS: COPAYMENT	264.00
		REIMBURSEMENT	9,742.70
		TOTAL NUMBER OF CLAIMS	179

Report : CLM-0808-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,147.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,784.00	14.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,286.00	216.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,586.00	7,823.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	23,949.00	2,439.00
EKG/ECG	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	706.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	77,697.00	426.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,371.00	661.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	504.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	130,904.00	12,083.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	130,904.00	12,083.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,006.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,690.00	CONTRACTUAL ALLOW	1,968.82
NON-COVERD CHARGES	316.00	TOTAL MEDICAID LIAB	721.18
		LESS: COB	715.18
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6.00	14.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	373.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	589.00	18.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,630.00	284.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	74.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,690.00	316.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,690.00	316.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:13:21
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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	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF 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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	50,842,586.10	ADJUSTMENTS	2,704,505.50
COVERED CHARGES	48,824,630.10	CONTRACTUAL ALLOW	36,009,341.08
NON-COVERD CHARGES	2,017,956.00	TOTAL MEDICAID LIAB	12,815,289.02
		LESS: COB	142,116.82
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	12,673,172.20

TOTAL NUMBER OF ADMISSIONS 1,825

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	6,083		0	3,345,650.00		887,405.00
ROUTINE NURSERY	1,160		0	1,088,401.00		6,798.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	7,243		0	4,434,051.00		894,203.00
SPECIAL CARE SERVICES						
CCU	1,356		0	1,160,445.00		0.00
ICU	1,292		0	1,526,296.00		0.00
NICU	596		0	1,295,802.00		0.00
PED ICU	17		0	20,570.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	3,261		0	4,003,113.00		0.00
TOTAL ACCOMODATIONS	10,504		0	8,437,164.00		894,203.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,740,361.85	880.00	OTHER LAB	221,467.00	0.00
MED/SURG SUPPLY	4,142,817.60	112,538.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,529,949.75	7,003.00	EDUCATION & TRAINING	5,160.00	72.00
RADIOLOGY-DIAGNOSTIC	578,257.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	839,202.00	442,868.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	94,713.50	630.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	752,985.00	0.00	MRI SERVICES	424,849.00	0.00
IV THERAPY	404,068.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,404,227.57	44,411.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,104,546.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,219,186.00	10,731.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	581,518.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,291,906.00	10,211.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	451,900.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	152,145.00
LABORATORY PATHOLOGIC	208,647.00	0.00	INJECTABLE DRUGS	2,130,929.79	132.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	45,848.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	60,074.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	288,629.00	64,456.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	763.00	3,241.00	TRAUMA RESPONSE	0.00	27,648.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,856,257.04	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	226.00
OTHER IMAGING SERVICE	180,678.00	54,600.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	275,802.50	133,057.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	204,325.00	56,098.00			
AUDIOLOGY	98,000.00	0.00			
CARDIOLOGY	1,092,859.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	11,316.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	146,223.00	2,805.00			
			TOTAL ANCILLARY	40,387,466.10	1,123,753.00
			TOTAL ACCOMODATIONS	8,437,164.00	894,203.00
			TOTAL CHARGES	48,824,630.10	2,017,956.00

Report : CLM-0800-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
282	1113340003201	11/05/13 - 11/08/13	12/30/13	0.00	226.00	0.00	0.00	0.00
TOTAL				0.00	226.00	0.00	0.00	0.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:13:42
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	817,303.87	ADJUSTMENTS	0.00
COVERED CHARGES	808,613.87	CONTRACTUAL ALLOW	567,313.81
NON-COVERD CHARGES	8,690.00	TOTAL MEDICAID LIAB	241,300.06
		LESS: COB	241,300.06
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 20

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	58		0	31,900.00		2,860.00
ROUTINE NURSERY	18		0	26,100.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	76		0	58,000.00		2,860.00
SPECIAL CARE SERVICES						
CCU	13		0	10,890.00		0.00
ICU	122		0	108,560.00		0.00
NICU	10		0	21,520.00		0.00
PED ICU	3		0	3,630.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	148		0	144,600.00		0.00
TOTAL ACCOMODATIONS	224		0	202,600.00		2,860.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	110,267.50	0.00	OTHER LAB	5,658.00	0.00
MED/SURG SUPPLY	67,005.12	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	100,817.00	0.00	EDUCATION & TRAINING	36.00	0.00
RADIOLOGY-DIAGNOSTIC	6,986.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,635.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,724.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,747.00	0.00	MRI SERVICES	3,430.00	0.00
IV THERAPY	34,548.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	68,149.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	79,460.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	16,202.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,447.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,526.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,216.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	4,150.00
LABORATORY PATHOLOGIC	1,321.00	0.00	INJECTABLE DRUGS	17,825.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,374.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,076.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	11,048.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	36.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	13,043.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,370.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,040.00	1,680.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	560.00	0.00			
CARDIOLOGY	1,846.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,620.00	0.00			
			TOTAL ANCILLARY	606,013.87	5,830.00
			TOTAL ACCOMODATIONS	202,600.00	2,860.00
			TOTAL CHARGES	808,613.87	8,690.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:13:48
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	37,557,090.69	ADJUSTMENTS	1,322,939.13
COVERED CHARGES	33,231,512.76	CONTRACTUAL ALLOW	27,097,328.49
NON-COVERD CHARGES	4,325,577.93	TOTAL MEDICAID LIAB	6,134,184.27
		LESS: COB	19,770.88
		LESS: COPAYMENT	12,915.00
		REIMBURSEMENT	6,101,498.39
		ALL OTHER	5,366,236.62
		FEE SCHEDULE-LAB	540,138.00
		INJECTABLE DRUGS	195,123.77

TOTAL NUMBER OF CLAIMS 14,317

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	389,389.35	2,392.50	OTHER LAB	172,374.00	1,875.00
MED/SURG SUPPLY	1,922,828.73	10,196.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	2,560.00	EDUCATION & TRAINING	5,916.00	490.40
RADIOLOGY-DIAGNOSTIC	1,049,467.00	23,007.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,056,007.00	172,081.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	80,853.00	25,943.03	FEE SCHEDULE LAB	6,050,138.38	1,405,260.00
EKG/ECG	423,571.00	95,184.00	MRI SERVICES	705,005.00	107,662.00
IV THERAPY	1,726,227.15	238,631.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,756,704.00	397,126.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	214,891.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	203,044.00	39,577.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	524,435.00	2,278.00	AMBULANCE	0.00	0.00
GI SERVICES	13,968.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,565,387.40	628,967.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	636,422.00	1,459.00	DRUG-SPECIFIC/HOME IV	0.00	5,600.00
LABORATORY PATHOLOGIC	0.00	592.00	INJECTABLE DRUGS	2,457,877.75	648,599.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	8,282.00
OCCUPATIONAL THERAPY	1,824.00	1,538.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,140.00	1,189.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	26,239.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	365,829.00	13,295.00	TRAUMA RESPONSE	0.00	54,432.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	186,269.00	0.00
LITHOTRIPSY	13,952.00	0.00	NO CC/INVALID REV CODE	0.00	763.00
OTHER IMAGING SERVICE	402,128.00	36,126.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	30,446.00	15,858.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	502,797.00	73,082.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	458,723.00	234,484.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	162,501.00	1,252.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,151,398.00	49,053.00			
			TOTAL ANCILLARY	33,231,512.76	4,325,073.93
			TOTAL ACCOMODATIONS	0.00	504.00
			TOTAL CHARGES	33,231,512.76	4,325,577.93

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	1113232004426	08/02/13 - 08/02/13	10/07/13	0.00	379.00	0.00	0.00	0.00
618	2314077000060	09/23/13 - 09/23/13	04/07/14	0.00	71.00	0.00	0.00	0.00
8213	5214098002083	01/16/14 - 01/16/14	05/19/14	0.00	226.00	0.00	0.00	0.00
638	2214297018640	03/05/14 - 03/05/14	10/27/14	0.00	50.00	0.00	2,011.25	0.00
838	2214297018640	03/05/14 - 03/05/14	10/27/14	0.00	37.00	0.00	2,011.25	0.00
TOTAL				0.00	763.00	0.00	4,022.50	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,200,926.51	ADJUSTMENTS	0.00
COVERED CHARGES	934,568.01	CONTRACTUAL ALLOW	372,305.18
NON-COVERD CHARGES	266,358.50	TOTAL MEDICAID LIAB	562,262.83
		LESS: COB	562,147.79
		LESS: COPAYMENT	115.04
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 294

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,388.75	0.00	OTHER LAB	8,499.00	0.00
MED/SURG SUPPLY	57,989.53	204.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	17.00	EDUCATION & TRAINING	72.00	0.00
RADIOLOGY-DIAGNOSTIC	29,331.00	398.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	31,974.00	59,942.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	608.00	76.00	FEE SCHEDULE LAB	179,672.98	19,258.00
EKG/ECG	8,055.00	652.00	MRI SERVICES	10,415.00	4,978.00
IV THERAPY	68,017.00	2,684.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	102,357.00	88,879.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	25,311.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,341.00	58.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	21,537.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	237,282.00	39,588.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	28,660.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	55,990.75	16,281.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	150.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,320.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,242.00	0.00	TRAUMA RESPONSE	0.00	8,640.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,429.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	82.00
OTHER IMAGING SERVICE	12,947.00	4,030.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,549.00	1,650.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,841.00	1,331.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,692.00	13,008.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	18,367.00	132.00			
			TOTAL ANCILLARY	934,568.01	266,358.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	934,568.01	266,358.50

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
102	1114295003030	06/08/14 - 06/08/14	11/10/14	0.00	82.00	0.00	5,000.00	0.00
TOTAL				0.00	82.00	0.00	5,000.00	0.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,750,316.50	ADJUSTMENTS	2,285.41
COVERED CHARGES	1,627,146.50	CONTRACTUAL ALLOW	1,565,396.42
NON-COVERD CHARGES	123,170.00	TOTAL MEDICAID LIAB	61,750.08
		LESS: COB	0.00
		LESS: COPAYMENT	2,384.01
		REIMBURSEMENT	59,366.07
		TOTAL NUMBER OF CLAIMS	1,151

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,728.00	0.00	OTHER LAB	958.00	0.00
MED/SURG SUPPLY	33,317.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	36.00	0.00
RADIOLOGY-DIAGNOSTIC	73,362.00	222.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	28,901.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	76.00	FEE SCHEDULE LAB	236,243.00	35,172.00
EKG/ECG	9,054.00	201.00	MRI SERVICES	8,510.00	3,426.00
IV THERAPY	23,969.00	3,069.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,522.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,850.00	58.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,131.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,111,416.00	67,706.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	899.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	67,466.50	10,204.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	438.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,976.00	2,486.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	882.00	550.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,488.00	0.00			
			TOTAL ANCILLARY	1,627,146.50	123,170.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,627,146.50	123,170.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	144,614.00	ADJUSTMENTS	0.00
COVERED CHARGES	126,839.50	CONTRACTUAL ALLOW	84,451.58
NON-COVERD CHARGES	17,774.50	TOTAL MEDICAID LIAB	42,387.92
		LESS: COB	42,295.92
		LESS: COPAYMENT	92.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	88

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	93.75	0.00	OTHER LAB	479.00	0.00
MED/SURG SUPPLY	3,438.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,183.00	205.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,327.00	3,274.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	24,080.00	4,030.00
EKG/ECG	1,250.00	250.00	MRI SERVICES	0.00	0.00
IV THERAPY	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	171.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	82,643.00	8,621.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,730.75	568.50
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	826.00	826.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	126,839.50	17,774.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	126,839.50	17,774.50

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,588,082.75	ADJUSTMENTS	206,884.63
COVERED CHARGES	4,263,113.55	CONTRACTUAL ALLOW	3,615,533.39
NON-COVERD CHARGES	324,969.20	TOTAL MEDICAID LIAB	647,580.16
		LESS: COB	33,990.82
		LESS: COPAYMENT	327.00
		REIMBURSEMENT	613,262.34
		TOTAL NUMBER OF CLAIMS	116

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	78,546.25	137.00	OTHER LAB	22,072.00	0.00
MED/SURG SUPPLY	417,275.20	119.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	50.00	EDUCATION & TRAINING	324.00	0.00
RADIOLOGY-DIAGNOSTIC	24,221.00	5,121.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	32,838.00	28,885.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	228.00	FEE SCHEDULE LAB	149,298.80	35,114.20
EKG/ECG	9,726.00	11,731.00	MRI SERVICES	5,093.00	0.00
IV THERAPY	228,185.00	30,504.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,416,842.00	19,312.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,013.00	1,358.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	153,935.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	57,506.00	2,127.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	148,328.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	433,849.30	149,421.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	161.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	769,462.00	0.00
LITHOTRIPSY	13,952.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,253.00	1,235.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,764.00	1,100.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	18,479.00	2,424.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	160,259.00	29,579.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	104,731.00	6,524.00			
			TOTAL ANCILLARY	4,263,113.55	324,969.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,263,113.55	324,969.20

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	183,546.10	ADJUSTMENTS	0.00
COVERED CHARGES	130,557.10	CONTRACTUAL ALLOW	28,039.61
NON-COVERD CHARGES	52,989.00	TOTAL MEDICAID LIAB	102,517.49
		LESS: COB	102,493.49
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

Report : CLM-0814-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,200.50	0.00	OTHER LAB	2,000.00	0.00
MED/SURG SUPPLY	8,253.85	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	199.00	390.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	152.00	FEE SCHEDULE LAB	6,562.00	34.00
EKG/ECG	201.00	451.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,904.00	1,296.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	55,340.00	48,598.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	690.00	58.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,457.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,907.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,441.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,706.75	1,061.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	24,297.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	516.00	685.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,882.00	264.00			
			TOTAL ANCILLARY	130,557.10	52,989.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	130,557.10	52,989.00

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:15:21
 Page: 1

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	34,391,429.41	ADJUSTMENTS	1,378,994.65
COVERED CHARGES	32,997,436.41	CONTRACTUAL ALLOW	25,242,313.23
NON-COVERD CHARGES	1,393,993.00	TOTAL MEDICAID LIAB	7,755,123.18
		LESS: COB	65,364.82
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,689,758.36

TOTAL NUMBER OF ADMISSIONS 1,176

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,517		0	3,511,685.00		605,823.00
ROUTINE NURSERY	1,406		39	1,735,994.00		415,563.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	4,923		39	5,247,679.00		1,021,386.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	398		0	1,410,583.00		0.00
NICU	128		0	678,640.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	526		0	2,089,223.00		0.00
TOTAL ACCOMODATIONS	5,449		39	7,336,902.00		1,021,386.00

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,231,137.00	37,439.00	OTHER LAB	88,894.00	0.00
MED/SURG SUPPLY	1,663,620.00	17,945.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,974,571.91	45,491.00	EDUCATION & TRAINING	2,055.00	0.00
RADIOLOGY-DIAGNOSTIC	620,832.00	0.00	OTHER THERAPEUTIC SVC	0.00	11,242.00
CT SCAN	953,741.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	176,291.00	131.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	157,456.00	0.00	MRI SERVICES	303,855.00	0.00
IV THERAPY	33,735.00	961.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,558,514.00	20,103.00	DURABLE MED. EQUIP.	0.00	904.00
LABOR/DELIVERY ROOM	1,167,182.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,323,075.00	748.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	348,501.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	779,673.00	9,950.00	SPECIAL SERVICES	0.00	49,450.00
RECOVERY ROOM	332,671.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	31,992.50
LABORATORY PATHOLOGIC	230,740.00	0.00	INJECTABLE DRUGS	5,215,673.50	7,144.00
RADIOLOGY THERAPEUTIC	55,214.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	94,408.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	53,462.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	163,038.00	9,545.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	68.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	751,145.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	221,255.00	60,550.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	331,967.00	52,689.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	92,514.00	15,391.00			
AUDIOLOGY	132,649.00	0.00			
CARDIOLOGY	570,438.00	931.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	12,261.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,898.00	0.00			
			TOTAL ANCILLARY	25,660,534.41	372,607.00
			TOTAL ACCOMODATIONS	7,336,902.00	1,021,386.00
			TOTAL CHARGES	32,997,436.41	1,393,993.00

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	717,457.50	ADJUSTMENTS	0.00
COVERED CHARGES	676,354.50	CONTRACTUAL ALLOW	336,667.97
NON-COVERD CHARGES	41,103.00	TOTAL MEDICAID LIAB	339,686.53
		LESS: COB	339,686.53
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 17

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	44		0	43,956.00		3,785.00
ROUTINE NURSERY	38		0	82,284.00		34,542.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	82		0	126,240.00		38,327.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	21		0	110,733.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	110,733.00		0.00
TOTAL ACCOMODATIONS	103		0	236,973.00		38,327.00

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,793.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	43,474.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	47,475.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,240.00	0.00	OTHER THERAPEUTIC SVC	876.00	0.00
CT SCAN	4,572.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	794.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	299.00	0.00	MRI SERVICES	7,552.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	52,424.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	26,244.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,087.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,389.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,787.00	0.00	SPECIAL SERVICES	0.00	2,776.00
RECOVERY ROOM	9,879.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,096.00	0.00	INJECTABLE DRUGS	64,611.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,243.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	96,936.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,080.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,299.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	1,595.00	0.00			
CARDIOLOGY	5,636.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	439,381.50	2,776.00
			TOTAL ACCOMODATIONS	236,973.00	38,327.00
			TOTAL CHARGES	676,354.50	41,103.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:15:27
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,395,203.36	ADJUSTMENTS	658,562.90
COVERED CHARGES	13,860,763.46	CONTRACTUAL ALLOW	11,390,208.25
NON-COVERD CHARGES	1,534,439.90	TOTAL MEDICAID LIAB	2,470,555.21
		LESS: COB	4,944.80
		LESS: COPAYMENT	7,004.52
		REIMBURSEMENT	2,458,605.89
		ALL OTHER	2,113,541.91
		FEE SCHEDULE-LAB	110,560.71
		INJECTABLE DRUGS	234,503.27

TOTAL NUMBER OF CLAIMS 3,851

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	411,915.40	2,719.50	OTHER LAB	171,644.00	0.00
MED/SURG SUPPLY	419,706.50	29,421.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	500.00	752.00
RADIOLOGY-DIAGNOSTIC	478,446.00	1,054.00	OTHER THERAPEUTIC SVC	0.00	1,288.00
CT SCAN	1,638,209.00	185,109.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	132,354.00	13,134.00	FEE SCHEDULE LAB	1,747,351.80	279,929.90
EKG/ECG	116,241.00	3,588.00	MRI SERVICES	398,806.00	31,634.00
IV THERAPY	521,069.00	62,333.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,113,737.00	125,875.00	DURABLE MED. EQUIP.	0.00	65.00
LABOR/DELIVERY ROOM	60,699.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	64,715.00	2,253.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	164,262.00	15,309.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,601,596.00	58,812.00	SPECIAL SERVICES	0.00	657.00
RECOVERY ROOM	211,953.00	1,347.00	DRUG-SPECIFIC/HOME IV	0.00	570.50
LABORATORY PATHOLOGIC	0.00	748.00	INJECTABLE DRUGS	1,655,035.10	370,468.00
RADIOLOGY THERAPEUTIC	517,634.00	122,707.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,133.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,316.00	658.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	68.00	1,261.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	112,811.00	12,763.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	655,542.00	117,612.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	71,959.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	179,049.00	8,787.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	197,541.00	77,689.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,565.00	0.00			
ORGAN ACQUISITION	0.00	4,232.00			
TREATMENT/OBSERV. RM	212,038.66	531.00			
			TOTAL ANCILLARY	13,860,763.46	1,534,439.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,860,763.46	1,534,439.90

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	312,955.00	ADJUSTMENTS	0.00
COVERED CHARGES	237,441.00	CONTRACTUAL ALLOW	114,487.74
NON-COVERD CHARGES	75,514.00	TOTAL MEDICAID LIAB	122,953.26
		LESS: COB	122,794.76
		LESS: COPAYMENT	158.50
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 118

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,180.00	0.00	OTHER LAB	546.00	0.00
MED/SURG SUPPLY	5,520.50	1,249.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	519.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,518.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,572.00	9,144.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,069.00	14,296.00	FEE SCHEDULE LAB	44,811.00	6,392.00
EKG/ECG	0.00	0.00	MRI SERVICES	3,776.00	4,643.00
IV THERAPY	8,549.00	628.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,392.00	11,402.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,294.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	660.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,976.00	567.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	77,381.00	2,123.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,136.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,501.50	9,378.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	34.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	18,413.00	14,485.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,252.00	654.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	666.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,228.00	0.00			
			TOTAL ANCILLARY	237,441.00	75,514.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	237,441.00	75,514.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	513,605.50	ADJUSTMENTS	1,188.67
COVERED CHARGES	496,644.50	CONTRACTUAL ALLOW	478,519.98
NON-COVERD CHARGES	16,961.00	TOTAL MEDICAID LIAB	18,124.52
		LESS: COB	0.00
		LESS: COPAYMENT	537.00
		REIMBURSEMENT	17,587.52
		TOTAL NUMBER OF CLAIMS	324

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,043.50	0.00	OTHER LAB	2,605.00	0.00
MED/SURG SUPPLY	5,219.00	40.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	30,712.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	26,207.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	83,347.00	5,222.00
EKG/ECG	4,770.00	0.00	MRI SERVICES	7,552.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,169.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	505.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	296,742.00	2,823.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,513.00	6,244.00
RADIOLOGY THERAPEUTIC	925.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,155.00	2,632.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	180.00	0.00			
			TOTAL ANCILLARY	496,644.50	16,961.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	496,644.50	16,961.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,659.00	ADJUSTMENTS	0.00
COVERED CHARGES	18,192.50	CONTRACTUAL ALLOW	11,011.09
NON-COVERD CHARGES	1,466.50	TOTAL MEDICAID LIAB	7,181.41
		LESS: COB	7,166.41
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 9

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 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	86.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	809.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,286.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,117.00	97.00
EKG/ECG	299.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,215.00	364.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	159.00	1,005.50
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	18,192.50	1,466.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,192.50	1,466.50

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,389,961.72	ADJUSTMENTS	133,976.32
COVERED CHARGES	2,029,799.92	CONTRACTUAL ALLOW	1,755,127.48
NON-COVERD CHARGES	360,161.80	TOTAL MEDICAID LIAB	274,672.44
		LESS: COB	0.00
		LESS: COPAYMENT	282.00
		REIMBURSEMENT	274,390.44
		TOTAL NUMBER OF CLAIMS	47

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,669.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	188,714.50	7,919.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	90,965.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,152.00	7,159.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	709.00	357.00	FEE SCHEDULE LAB	75,249.50	17,468.80
EKG/ECG	5,368.00	1,196.00	MRI SERVICES	7,552.00	3,776.00
IV THERAPY	40,562.00	1,884.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	358,301.00	151,582.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,659.00	2,412.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	49,384.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,776.00	437.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	26,914.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	359,062.50	68,358.00
RADIOLOGY THERAPEUTIC	56,747.00	1,217.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	677.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,948.00	225.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	78.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	463,806.00	30,279.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,947.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	23,499.00	465.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	170,009.00	65,304.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	36,051.42	123.00			
			TOTAL ANCILLARY	2,029,799.92	360,161.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,029,799.92	360,161.80

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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SUMMARY TYPE VIII

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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	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,092,065.74	ADJUSTMENTS	310,133.37
COVERED CHARGES	2,727,570.89	CONTRACTUAL ALLOW	476,631.10
NON-COVERD CHARGES	364,494.85	TOTAL MEDICAID LIAB	2,250,939.79
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,250,939.79

TOTAL NUMBER OF ADMISSIONS 109

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,946		0	1,682,050.00		264,950.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,946		0	1,682,050.00		264,950.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	1,946		0	1,682,050.00		264,950.00

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	232,714.00	24,138.00	OTHER LAB	3,628.00	0.00
MED/SURG SUPPLY	64,853.89	21,150.00	RECREATIONAL THERAPY	53.00	0.00
LABORATORY-GENERAL	52,441.00	4,177.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,528.00	711.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,718.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	209,309.00	2,796.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,830.00	69.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	46,478.00	24,784.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	11,082.85
GI SERVICES	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	717.00	478.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	287,050.00	5,144.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	111,893.00	5,015.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	13,775.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,708.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	307.00	0.00			
CARDIOLOGY	518.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,045,520.89	99,544.85
			TOTAL ACCOMODATIONS	1,682,050.00	264,950.00
			TOTAL CHARGES	2,727,570.89	364,494.85

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:15:58
Page: 9

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROOSEVELT WARM SPRINGS REHABILITATION & SPECIALTY	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
6135 ROOSEVELT HWY	000000778A	SERVICE DATES	07/01/13	THROUGH	06/30/14
WARM SPRINGS,GA 31830-2757		ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000789A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	256,609,376.55	ADJUSTMENTS	13,798,210.95
COVERED CHARGES	248,635,258.48	CONTRACTUAL ALLOW	208,775,010.17
NON-COVERD CHARGES	7,974,118.07	TOTAL MEDICAID LIAB	39,860,248.31
		LESS: COB	233,170.79
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	39,627,077.52

TOTAL NUMBER OF ADMISSIONS 4,884

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	16,010		65	21,997,814.00		2,029,116.00
ROUTINE NURSERY	2,622		46	3,498,610.00		86,412.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	18,632		111	25,496,424.00		2,115,528.00
SPECIAL CARE SERVICES						
CCU	642		0	2,475,178.00		15,284.00
ICU	7,398		8	21,810,370.00		47,984.00
NICU	429		0	1,509,906.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	8,469		8	25,795,454.00		63,268.00
TOTAL ACCOMODATIONS	27,101		119	51,291,878.00		2,178,796.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	67,669,806.87	630,747.95	OTHER LAB	535,774.77	1,198.00
MED/SURG SUPPLY	16,408,052.27	871,814.08	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	29,597,291.81	267,530.66	EDUCATION & TRAINING	29,055.00	745.00
RADIOLOGY-DIAGNOSTIC	4,206,502.40	18,492.64	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,179,710.67	145,096.17	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,024,312.77	35,325.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	766,553.80	680.00	MRI SERVICES	2,356,424.33	40,528.00
IV THERAPY	4,570.48	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,418,632.80	138,931.90	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,736,154.61	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,106,282.34	109,491.29	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,127,269.23	15,342.00	AMBULANCE	0.00	0.00
GI SERVICES	454,196.82	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,721,983.85	80,590.83	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,705,610.47	5,957.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	849,969.00	0.00	INJECTABLE DRUGS	286,903.14	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	573,536.97	9,861.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	462,006.08	1,576.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	764,568.74	16,165.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	51,733.64	1,027.44	TRAUMA RESPONSE	0.00	1,181,433.35
PSYCHIATRIC SERVICES	1,221,360.32	0.00	IMPL DEV CHARGE PATIENTS	6,670,183.56	47,654.00
LITHOTRIPSY	60,158.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,159,183.47	14,919.30			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	2,143,626.98			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,114,107.62	10,133.48			
AUDIOLOGY	131,522.26	0.00			
CARDIOLOGY	3,612,043.35	6,384.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	153,817.04	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	184,102.00	71.00			
			TOTAL ANCILLARY	197,343,380.48	5,795,322.07
			TOTAL ACCOMODATIONS	51,291,878.00	2,178,796.00
			TOTAL CHARGES	248,635,258.48	7,974,118.07

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,240,273.70	ADJUSTMENTS	0.00
COVERED CHARGES	1,215,747.70	CONTRACTUAL ALLOW	1,013,098.15
NON-COVERD CHARGES	24,526.00	TOTAL MEDICAID LIAB	202,649.55
		LESS: COB	202,649.55
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	9		0	12,546.00		729.00
ROUTINE NURSERY	0		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	12,546.00		729.00
SPECIAL CARE SERVICES						
CCU	26		0	99,346.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	26		0	99,346.00		0.00
TOTAL ACCOMODATIONS	35		0	111,892.00		729.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	396,404.63	0.00	OTHER LAB	1,490.00	0.00
MED/SURG SUPPLY	108,241.52	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	54,772.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	23,808.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	37,548.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	340.00	0.00	MRI SERVICES	5,229.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	78,679.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	21,258.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	113,753.55	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	20,778.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,786.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,989.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	15,807.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,040.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	21,075.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	213,994.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	938.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	2,722.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,103,855.70	23,797.00
			TOTAL ACCOMODATIONS	111,892.00	729.00
			TOTAL CHARGES	1,215,747.70	24,526.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:16:32
Page: 5

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

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	65,912,760.48	ADJUSTMENTS	1,214,243.99
COVERED CHARGES	57,715,987.40	CONTRACTUAL ALLOW	50,960,016.56
NON-COVERD CHARGES	8,196,773.08	TOTAL MEDICAID LIAB	6,755,970.84
		LESS: COB	963.88
		LESS: COPAYMENT	9,152.35
		REIMBURSEMENT	6,745,854.61
		ALL OTHER	6,134,441.93
		FEE SCHEDULE-LAB	550,707.44
		INJECTABLE DRUGS	60,705.24
		TOTAL NUMBER OF CLAIMS	15,606

SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,280,587.83	19,883.56	OTHER LAB	230,056.59	0.00
MED/SURG SUPPLY	2,770,037.94	55,100.99	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	745.00
RADIOLOGY-DIAGNOSTIC	3,568,374.26	26,286.44	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,960,808.98	1,446,358.21	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	297.00	4,548.06	FEE SCHEDULE LAB	10,248,067.64	2,634,017.29
EKG/ECG	705,805.40	14,108.30	MRI SERVICES	1,017,633.27	49,457.00
IV THERAPY	2,818,428.13	76,050.83	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,999,321.48	1,600,326.36	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	252,662.90	146,491.39	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,445,393.12	0.00	AMBULANCE	0.00	0.00
GI SERVICES	245,044.44	36,531.82	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,369,528.84	49,496.38	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	721,964.58	0.00	DRUG-SPECIFIC/HOME IV	0.00	10,651.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,150,592.62	806,129.53
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,103.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	588.00	2,905.06	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	17,275.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	203,108.60	33,985.66	TRAUMA RESPONSE	0.00	180,974.54
PSYCHIATRIC SERVICES	344,404.76	0.00	IMPL DEV CHARGE PATIENTS	278,893.31	241,732.27
LITHOTRIPSY	386,740.71	45,945.67	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,930,173.62	331,988.46			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,388.00	45,080.10			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	609,152.46	45,633.00			
AUDIOLOGY	4,123.88	428.00			
CARDIOLOGY	267,223.12	152,613.66			
AMBULATORY SURGERY	4,306.71	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	522,618.41	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	378,660.80	119,926.50			
			TOTAL ANCILLARY	57,715,987.40	8,196,773.08
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	57,715,987.40	8,196,773.08

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:17:17
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	114,893.67	ADJUSTMENTS	0.00
COVERED CHARGES	65,003.48	CONTRACTUAL ALLOW	51,343.40
NON-COVERD CHARGES	49,890.19	TOTAL MEDICAID LIAB	13,660.08
		LESS: COB	13,651.08
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 18

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	985.05	1,985.75	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,579.95	97.06	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,762.54	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,498.70	7,262.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,311.20	1,931.92
EKG/ECG	340.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,763.20	371.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	18,294.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	130.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,185.60	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,224.17	1,030.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,437.96	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,170.11	857.71
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	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	429.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,186.00	2,711.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	15,349.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	65,003.48	49,890.19
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	65,003.48	49,890.19

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:17:21
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ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,836,859.80	ADJUSTMENTS	2,773.88
COVERED CHARGES	3,581,849.71	CONTRACTUAL ALLOW	3,444,796.76
NON-COVERD CHARGES	255,010.09	TOTAL MEDICAID LIAB	137,052.95
		LESS: COB	0.00
		LESS: COPAYMENT	5,301.00
		REIMBURSEMENT	131,751.95
		TOTAL NUMBER OF CLAIMS	2,450

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	103,843.98	966.84	OTHER LAB	3,659.89	0.00
MED/SURG SUPPLY	48,438.36	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	145,996.12	1,218.08	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	149,873.37	45,134.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	609,770.62	160,216.35
EKG/ECG	30,917.90	0.00	MRI SERVICES	24,957.00	4,311.00
IV THERAPY	208,011.51	5,893.96	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,533.62	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,385.25	241.60	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	2,041,461.49	3,389.56	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	127,358.09	10,447.81
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	588.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	304.00	74.90	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	20,948.16	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	56,782.46	20,336.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,523.89	884.09			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,084.00	1,307.90			
			TOTAL ANCILLARY	3,581,849.71	255,010.09
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,581,849.71	255,010.09

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	698.41	ADJUSTMENTS	0.00
COVERED CHARGES	698.41	CONTRACTUAL ALLOW	364.33
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	334.08
		LESS: COB	331.08
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

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SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 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	698.41	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	698.41	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	698.41	0.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,547,333.33	ADJUSTMENTS	133,387.44
COVERED CHARGES	3,192,707.41	CONTRACTUAL ALLOW	2,777,675.65
NON-COVERD CHARGES	354,625.92	TOTAL MEDICAID LIAB	415,031.76
		LESS: COB	0.00
		LESS: COPAYMENT	333.00
		REIMBURSEMENT	414,698.76

TOTAL NUMBER OF CLAIMS 69

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	144,812.99	540.72	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	577,987.98	9,991.26	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,978.00	1,380.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,848.00	25,294.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,310.00	FEE SCHEDULE LAB	78,944.50	19,456.50
EKG/ECG	6,120.00	1,700.00	MRI SERVICES	0.00	4,311.00
IV THERAPY	4,751.00	1,860.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	894,990.78	83,295.86	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	11,867.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	35,450.00	113.45	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	329,408.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,855.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	116,218.22	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	141,793.67	48,099.11
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,278.02	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	53.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	381,377.27	37,430.00
LITHOTRIPSY	330,869.00	30,079.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,663.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	2,722.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	36,045.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	18,208.00	77,972.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	29,520.00	7,740.00			
			TOTAL ANCILLARY	3,192,707.41	354,625.92
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,192,707.41	354,625.92

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER
000000789A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:17:48
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

KINGS BAY COMMUNITY HOSPITAL INC
 2000 DAN PROCTOR DR
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER 000000811A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,780,808.24	ADJUSTMENTS	221,439.61
COVERED CHARGES	1,709,017.10	CONTRACTUAL ALLOW	819,941.10
NON-COVERD CHARGES	71,791.14	TOTAL MEDICAID LIAB	889,076.00
		LESS: COB	4,000.47
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	885,075.53

TOTAL NUMBER OF ADMISSIONS 136

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	325		0	289,390.00		46,077.00
ROUTINE NURSERY	83		0	74,036.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	408		0	363,426.00		46,077.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	49		0	97,069.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	49		0	97,069.00		0.00
TOTAL ACCOMODATIONS	457		0	460,495.00		46,077.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

KINGS BAY COMMUNITY HOSPITAL INC
 2000 DAN PROCTOR DR
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	323,655.70	11,632.14	OTHER LAB	3,912.00	0.00
MED/SURG SUPPLY	159,562.40	1,060.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	175,061.00	7,325.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,508.00	213.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	46,278.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,693.00	754.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,985.00	0.00	MRI SERVICES	15,540.00	0.00
IV THERAPY	20,667.00	379.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	154,092.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	37,733.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	75,177.00	30.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	49,674.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	42,516.00	89.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	23,326.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,294.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	201.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,725.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	17,903.00	4,232.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,464.00	0.00			
AUDIOLOGY	6,643.00	0.00			
CARDIOLOGY	19,849.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,500.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	21,563.00	0.00			
			TOTAL ANCILLARY	1,248,522.10	25,714.14
			TOTAL ACCOMODATIONS	460,495.00	46,077.00
			TOTAL CHARGES	1,709,017.10	71,791.14

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

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

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SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

KINGS BAY COMMUNITY HOSPITAL INC
 2000 DAN PROCTOR DR
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	127,270.52	ADJUSTMENTS	0.00
COVERED CHARGES	124,102.52	CONTRACTUAL ALLOW	36,283.30
NON-COVERD CHARGES	3,168.00	TOTAL MEDICAID LIAB	87,819.22
		LESS: COB	87,819.22
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 11

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	35		0	34,125.00		3,168.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	35		0	34,125.00		3,168.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	35		0	34,125.00		3,168.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

KINGS BAY COMMUNITY HOSPITAL INC
 2000 DAN PROCTOR DR
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,267.42	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,248.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,490.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	823.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,075.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	272.00	0.00	MRI SERVICES	1,860.00	0.00
IV THERAPY	1,490.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,180.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	10,728.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,222.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,039.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,648.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,618.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	91.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,926.00	0.00			
			TOTAL ANCILLARY	89,977.52	0.00
			TOTAL ACCOMODATIONS	34,125.00	3,168.00
			TOTAL CHARGES	124,102.52	3,168.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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KINGS BAY COMMUNITY HOSPITAL INC
2000 DAN PROCTOR DR
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,840,790.16	ADJUSTMENTS	141,832.97
COVERED CHARGES	2,678,029.74	CONTRACTUAL ALLOW	1,930,768.99
NON-COVERD CHARGES	162,760.42	TOTAL MEDICAID LIAB	747,260.75
		LESS: COB	1,774.56
		LESS: COPAYMENT	2,283.00
		REIMBURSEMENT	743,203.19
		ALL OTHER	615,126.35
		FEE SCHEDULE-LAB	77,099.64
		INJECTABLE DRUGS	50,977.20

TOTAL NUMBER OF CLAIMS 2,643

KINGS BAY COMMUNITY HOSPITAL INC
 2000 DAN PROCTOR DR
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	123,198.86	2,226.46	OTHER LAB	39,102.00	0.00
MED/SURG SUPPLY	71,026.01	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	22.00	EDUCATION & TRAINING	486.00	68.00
RADIOLOGY-DIAGNOSTIC	142,334.00	1,523.00	OTHER THERAPEUTIC SVC	0.00	2,834.00
CT SCAN	257,862.00	9,000.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	724.00	467.00	FEE SCHEDULE LAB	402,967.01	70,519.35
EKG/ECG	27,713.00	1,494.00	MRI SERVICES	86,884.00	0.00
IV THERAPY	125,624.00	12,895.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	83,440.00	3,454.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	16,927.00	1,334.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	22,222.00	2,590.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	23,590.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	719,451.00	10,711.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,941.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	205,732.86	30,589.61
RADIOLOGY THERAPEUTIC	164,063.00	3,741.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	96.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	201.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,462.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	74,028.00	2,737.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,929.00	1,191.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	20,815.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	14,677.00	1,508.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,090.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	29,741.00	3,266.00			
			TOTAL ANCILLARY	2,678,029.74	162,467.42
			TOTAL ACCOMODATIONS	0.00	293.00
			TOTAL CHARGES	2,678,029.74	162,760.42

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

KINGS BAY COMMUNITY HOSPITAL INC
2000 DAN PROCTOR DR
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	101,295.58	ADJUSTMENTS	0.00
COVERED CHARGES	86,700.13	CONTRACTUAL ALLOW	33,232.25
NON-COVERD CHARGES	14,595.45	TOTAL MEDICAID LIAB	53,467.88
		LESS: COB	53,446.88
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 80

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

KINGS BAY COMMUNITY HOSPITAL INC
 2000 DAN PROCTOR DR
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,867.39	70.70	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,087.39	118.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	38.00	EDUCATION & TRAINING	108.00	0.00
RADIOLOGY-DIAGNOSTIC	6,488.00	639.00	OTHER THERAPEUTIC SVC	0.00	117.00
CT SCAN	4,574.00	2,434.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	221.00	FEE SCHEDULE LAB	13,386.00	1,994.00
EKG/ECG	1,153.00	136.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,096.00	314.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,260.00	1,468.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,379.00	731.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	906.00	623.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,304.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	25,828.00	507.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	780.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,203.35	3,172.35
RADIOLOGY THERAPEUTIC	5,678.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	72.40
OTHER IMAGING SERVICE	1,722.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	880.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,508.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	432.00			
			TOTAL ANCILLARY	86,700.13	14,595.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	86,700.13	14,595.45

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

KINGS BAY COMMUNITY HOSPITAL INC
2000 DAN PROCTOR DR
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
663	2213351012175	06/11/13 - 06/12/13	12/23/13	0.00	36.20	0.00	3,179.60	0.00
6363	2214302012016	02/07/14 - 02/08/14	11/03/14	0.00	36.20	0.00	2,283.03	0.00
TOTAL				0.00	72.40	0.00	5,462.63	0.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
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SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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KINGS BAY COMMUNITY HOSPITAL INC
2000 DAN PROCTOR DR
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	204,533.57	ADJUSTMENTS	812.10
COVERED CHARGES	199,064.07	CONTRACTUAL ALLOW	179,925.91
NON-COVERD CHARGES	5,469.50	TOTAL MEDICAID LIAB	19,138.16
		LESS: COB	67.29
		LESS: COPAYMENT	483.00
		REIMBURSEMENT	18,587.87
		TOTAL NUMBER OF CLAIMS	343

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

KINGS BAY COMMUNITY HOSPITAL INC
 2000 DAN PROCTOR DR
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,892.95	36.20	OTHER LAB	462.00	0.00
MED/SURG SUPPLY	1,193.41	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,691.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,222.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	32,602.00	4,456.00
EKG/ECG	1,356.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,383.00	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	589.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	128,553.00	117.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,051.71	663.30
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	4,068.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	199,064.07	5,469.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	199,064.07	5,469.50

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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KINGS BAY COMMUNITY HOSPITAL INC
2000 DAN PROCTOR DR
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,762.55	ADJUSTMENTS	0.00
COVERED CHARGES	4,155.85	CONTRACTUAL ALLOW	1,982.20
NON-COVERD CHARGES	606.70	TOTAL MEDICAID LIAB	2,173.65
		LESS: COB	2,164.65
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	6

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

KINGS BAY COMMUNITY HOSPITAL INC
 2000 DAN PROCTOR DR
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	458.70	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	28.00	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	970.00	148.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,822.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	122.85	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,155.85	606.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,155.85	606.70

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

KINGS BAY COMMUNITY HOSPITAL INC
2000 DAN PROCTOR DR
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	73,555.34	ADJUSTMENTS	14,841.39
COVERED CHARGES	72,528.54	CONTRACTUAL ALLOW	52,688.02
NON-COVERD CHARGES	1,026.80	TOTAL MEDICAID LIAB	19,840.52
		LESS: COB	0.00
		LESS: COPAYMENT	84.00
		REIMBURSEMENT	19,756.52

TOTAL NUMBER OF CLAIMS 4

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

KINGS BAY COMMUNITY HOSPITAL INC
 2000 DAN PROCTOR DR
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,306.20	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	254.04	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	702.00
CT SCAN	721.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	498.00	180.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,123.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	39,750.30	144.80
RADIOLOGY THERAPEUTIC	20,876.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	72,528.54	1,026.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	72,528.54	1,026.80

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:18:12
Page: 16

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

KINGS BAY COMMUNITY HOSPITAL INC
2000 DAN PROCTOR DR
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	39,004.00	ADJUSTMENTS	0.00
COVERED CHARGES	39,004.00	CONTRACTUAL ALLOW	7,570.74
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	31,433.26
		LESS: COB	31,373.26
		LESS: COPAYMENT	60.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

KINGS BAY COMMUNITY HOSPITAL INC
 2000 DAN PROCTOR DR
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	39,004.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	39,004.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	39,004.00	0.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

GLYNN-BRUNSWICK MEMORIAL HOSPITAL
 2415 PARKWOOD DR
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER 000000822A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,728,014.79	ADJUSTMENTS	1,045,785.90
COVERED CHARGES	23,305,314.27	CONTRACTUAL ALLOW	15,381,815.91
NON-COVERD CHARGES	422,700.52	TOTAL MEDICAID LIAB	7,923,498.36
		LESS: COB	19,328.59
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,904,169.77

TOTAL NUMBER OF ADMISSIONS 914

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,530		0	2,435,811.00		142,231.00
ROUTINE NURSERY	345		0	307,823.00		32.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,875		0	2,743,634.00		142,263.00
SPECIAL CARE SERVICES						
CCU	369		0	731,149.00		0.00
ICU	1,608		1	2,590,406.00		4,473.00
NICU	31		0	50,096.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,008		1	3,371,651.00		4,473.00
TOTAL ACCOMODATIONS	4,883		1	6,115,285.00		146,736.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

GLYNN-BRUNSWICK MEMORIAL HOSPITAL
 2415 PARKWOOD DR
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,978,698.03	10,497.01	OTHER LAB	74,444.00	0.00
MED/SURG SUPPLY	2,081,215.48	11,052.09	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,792,669.06	16,491.00	EDUCATION & TRAINING	2,750.00	110.00
RADIOLOGY-DIAGNOSTIC	406,150.00	0.00	OTHER THERAPEUTIC SVC	0.00	595.00
CT SCAN	365,330.00	125,388.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	133,969.13	215.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	81,324.00	0.00	MRI SERVICES	175,599.00	0.00
IV THERAPY	273,940.28	17,273.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,477,993.00	1,793.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	141,094.00	0.00	REHAB THERAPY	960.00	0.00
RESPIRATORY SERVICES	1,184,460.25	3,859.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	459,205.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	329,892.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	173,079.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	109,299.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	96,907.02	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	22,695.02	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	202,612.00	7,936.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	45,346.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	7,155.67
OTHER IMAGING SERVICE	65,032.00	6,823.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	440,001.00	51,775.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	76,064.00	15,001.00			
AUDIOLOGY	29,110.00	0.00			
CARDIOLOGY	856,478.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	26,348.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	87,365.00	0.00			
			TOTAL ANCILLARY	17,190,029.27	275,964.52
			TOTAL ACCOMODATIONS	6,115,285.00	146,736.00
			TOTAL CHARGES	23,305,314.27	422,700.52

Report : CLM-0800-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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SUMMARY TYPE I
INPATIENT PAID CLAIMS

GLYNN-BRUNSWICK MEMORIAL HOSPITAL
2415 PARKWOOD DR
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2213198013215	07/01/13 - 07/10/13	07/22/13	0.00	2,700.00	0.00	0.00	0.00
615	5913268001058	09/10/13 - 09/17/13	09/30/13	0.00	1,860.00	0.00	0.00	0.00
615	2214073011534	01/01/14 - 01/31/14	03/17/14	0.00	1,860.00	0.00	0.00	0.00
2	2214074000322	01/01/14 - 01/02/14	03/24/14	0.00	735.67	0.00	0.00	0.00
TOTAL				0.00	7,155.67	0.00	0.00	0.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:18:29
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SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

GLYNN-BRUNSWICK MEMORIAL HOSPITAL
 2415 PARKWOOD DR
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	284,437.49	ADJUSTMENTS	0.00
COVERED CHARGES	277,309.49	CONTRACTUAL ALLOW	64,255.54
NON-COVERD CHARGES	7,128.00	TOTAL MEDICAID LIAB	213,053.95
		LESS: COB	213,053.95
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 17

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	54		0	51,730.00		7,128.00
ROUTINE NURSERY	0		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	51,730.00		7,128.00
SPECIAL CARE SERVICES						
CCU	4		0	7,924.00		0.00
ICU	5		0	9,905.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	17,829.00		0.00
TOTAL ACCOMODATIONS	63		0	69,559.00		7,128.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

GLYNN-BRUNSWICK MEMORIAL HOSPITAL
 2415 PARKWOOD DR
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	52,870.16	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,165.33	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	17,913.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,049.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,064.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	531.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	272.00	0.00	MRI SERVICES	1,860.00	0.00
IV THERAPY	1,969.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	63,128.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,862.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,733.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,049.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,294.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,391.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	286.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	55.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,618.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,008.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	788.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,845.00	0.00			
			TOTAL ANCILLARY	207,750.49	0.00
			TOTAL ACCOMODATIONS	69,559.00	7,128.00
			TOTAL CHARGES	277,309.49	7,128.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:18:32
Page: 6

GLYNN-BRUNSWICK MEMORIAL HOSPITAL
2415 PARKWOOD DR
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,133,660.04	ADJUSTMENTS	869,638.73
COVERED CHARGES	11,295,424.76	CONTRACTUAL ALLOW	8,491,280.66
NON-COVERD CHARGES	838,235.28	TOTAL MEDICAID LIAB	2,804,144.10
		LESS: COB	1,838.90
		LESS: COPAYMENT	11,738.77
		REIMBURSEMENT	2,790,566.43
		ALL OTHER	2,244,090.23
		FEE SCHEDULE-LAB	305,211.88
		INJECTABLE DRUGS	241,264.32

TOTAL NUMBER OF CLAIMS 8,120

GLYNN-BRUNSWICK MEMORIAL HOSPITAL
 2415 PARKWOOD DR
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	822,163.62	7,623.87	OTHER LAB	160,097.00	0.00
MED/SURG SUPPLY	476,241.91	9,130.20	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	414.00	EDUCATION & TRAINING	163.00	55.00
RADIOLOGY-DIAGNOSTIC	480,816.00	17,144.00	OTHER THERAPEUTIC SVC	0.00	8,992.00
CT SCAN	775,369.00	57,795.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	93,101.00	20,753.06	FEE SCHEDULE LAB	1,471,138.71	227,434.58
EKG/ECG	91,939.00	2,309.00	MRI SERVICES	403,934.00	10,942.00
IV THERAPY	461,471.00	32,275.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	741,321.85	122,098.17	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	42,723.00	11,825.00	REHAB THERAPY	1,367.00	0.00
RESPIRATORY SERVICES	103,644.30	4,461.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	160,279.00	485.00	AMBULANCE	0.00	0.00
GI SERVICES	25,668.00	1,037.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,515,239.00	22,607.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	119,730.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	925,828.05	136,886.35
RADIOLOGY THERAPEUTIC	1,258,324.10	24,677.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	12,711.00	8,788.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,314.00	2,137.03	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	12,778.00	541.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	983.00	0.00
LITHOTRIPSY	38,985.00	0.00	NO CC/INVALID REV CODE	0.00	304.00
OTHER IMAGING SERVICE	420,019.00	39,077.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	114,573.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	91,632.00	3,180.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	165,569.00	53,465.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	9,110.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	296,192.22	11,799.00			
			TOTAL ANCILLARY	11,295,424.76	838,235.28
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,295,424.76	838,235.28

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:18:32
Page: 8

GLYNN-BRUNSWICK MEMORIAL HOSPITAL
2415 PARKWOOD DR
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
462	2213323009409	07/14/13 - 07/14/13	11/25/13	0.00	293.00	0.00	0.00	0.00
30	2214156022658	04/07/14 - 04/07/14	06/09/14	0.00	11.00	0.00	0.00	0.00
TOTAL				0.00	304.00	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:19:15
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GLYNN-BRUNSWICK MEMORIAL HOSPITAL
2415 PARKWOOD DR
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	351,402.03	ADJUSTMENTS	0.00
COVERED CHARGES	273,687.97	CONTRACTUAL ALLOW	101,153.92
NON-COVERD CHARGES	77,714.06	TOTAL MEDICAID LIAB	172,534.05
		LESS: COB	172,378.05
		LESS: COPAYMENT	156.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 168

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GLYNN-BRUNSWICK MEMORIAL HOSPITAL
 2415 PARKWOOD DR
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,588.94	652.32	OTHER LAB	1,238.00	0.00
MED/SURG SUPPLY	15,438.03	2,262.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	102.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,487.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,562.00	8,808.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	34,822.00	5,617.00
EKG/ECG	1,768.00	408.00	MRI SERVICES	8,861.00	2,454.00
IV THERAPY	22,543.00	1,213.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	27,771.00	9,680.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	802.00	159.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	561.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,968.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	31,064.00	581.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,972.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	43,546.00	33,971.84
RADIOLOGY THERAPEUTIC	4,405.00	587.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	367.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	12,995.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	14,466.00	4,282.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,991.00	3,573.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	880.00	108.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,592.00	3,255.00			
			TOTAL ANCILLARY	273,687.97	77,714.06
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	273,687.97	77,714.06

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:19:18
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GLYNN-BRUNSWICK MEMORIAL HOSPITAL
2415 PARKWOOD DR
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	621,343.10	ADJUSTMENTS	2,796.80
COVERED CHARGES	601,346.60	CONTRACTUAL ALLOW	555,084.23
NON-COVERD CHARGES	19,996.50	TOTAL MEDICAID LIAB	46,262.37
		LESS: COB	37.00
		LESS: COPAYMENT	1,527.07
		REIMBURSEMENT	44,698.30
		TOTAL NUMBER OF CLAIMS	827

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

GLYNN-BRUNSWICK MEMORIAL HOSPITAL
 2415 PARKWOOD DR
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,243.97	72.40	OTHER LAB	5,052.00	0.00
MED/SURG SUPPLY	1,171.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,037.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	26,785.00	975.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,434.00	3,643.00	FEE SCHEDULE LAB	95,566.00	5,607.00
EKG/ECG	6,060.00	0.00	MRI SERVICES	1,860.00	0.00
IV THERAPY	24,861.00	197.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	616.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,746.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	322,910.00	2,546.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,591.63	2,779.10
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	948.00	571.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	501.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	21,194.00	3,606.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,751.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,019.00	0.00			
			TOTAL ANCILLARY	601,346.60	19,996.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	601,346.60	19,996.50

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GLYNN-BRUNSWICK MEMORIAL HOSPITAL
2415 PARKWOOD DR
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,830.50	ADJUSTMENTS	0.00
COVERED CHARGES	15,940.25	CONTRACTUAL ALLOW	7,703.99
NON-COVERD CHARGES	1,890.25	TOTAL MEDICAID LIAB	8,236.26
		LESS: COB	8,218.26
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	17

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GLYNN-BRUNSWICK MEMORIAL HOSPITAL
 2415 PARKWOOD DR
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	913.65	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	11.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	184.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,794.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,021.00	212.00
EKG/ECG	136.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	682.00	314.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,909.00	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	289.60	609.25
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	755.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	15,940.25	1,890.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,940.25	1,890.25

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GLYNN-BRUNSWICK MEMORIAL HOSPITAL
2415 PARKWOOD DR
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,110,720.18	ADJUSTMENTS	87,928.76
COVERED CHARGES	1,088,885.44	CONTRACTUAL ALLOW	919,261.18
NON-COVERD CHARGES	21,834.74	TOTAL MEDICAID LIAB	169,624.26
		LESS: COB	0.00
		LESS: COPAYMENT	342.00
		REIMBURSEMENT	169,282.26

TOTAL NUMBER OF CLAIMS 31

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GLYNN-BRUNSWICK MEMORIAL HOSPITAL
 2415 PARKWOOD DR
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	79,344.71	0.00	OTHER LAB	420.00	0.00
MED/SURG SUPPLY	265,392.42	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,505.00	2,377.00	OTHER THERAPEUTIC SVC	0.00	351.00
CT SCAN	8,272.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	281.00	829.02	FEE SCHEDULE LAB	3,326.00	613.00
EKG/ECG	544.00	136.00	MRI SERVICES	0.00	0.00
IV THERAPY	24,076.00	197.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	351,105.01	6,537.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	144.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,832.00	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	3,954.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	120,279.90	7,404.70
RADIOLOGY THERAPEUTIC	160,333.40	681.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,201.02	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	243.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	46,995.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	324.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,508.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,514.00	0.00			
			TOTAL ANCILLARY	1,088,885.44	21,834.74
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,088,885.44	21,834.74

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:19:29
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GLYNN-BRUNSWICK MEMORIAL HOSPITAL
2415 PARKWOOD DR
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
000000822A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/13	THROUGH	04/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

GORDON HOSPITAL
 1035 RED BUD RD NE
 CALHOUN,GA 30701-2082

PROVIDER NUMBER 000000833A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,275,745.43	ADJUSTMENTS	184,598.76
COVERED CHARGES	11,498,728.10	CONTRACTUAL ALLOW	8,585,594.43
NON-COVERD CHARGES	777,017.33	TOTAL MEDICAID LIAB	2,913,133.67
		LESS: COB	7,510.45
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,905,623.22

TOTAL NUMBER OF ADMISSIONS 426

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	730		8	417,560.00		17,239.04
ROUTINE NURSERY	117		2	59,486.46		1,046.32
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	847		10	477,046.46		18,285.36
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	681		0	1,079,320.53		9,362.16
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	681		0	1,079,320.53		9,362.16
TOTAL ACCOMODATIONS	1,528		10	1,556,366.99		27,647.52

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

GORDON HOSPITAL
 1035 RED BUD RD NE
 CALHOUN,GA 30701-2082

PROVIDER NUMBER
 000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	416,185.34	764.20	OTHER LAB	28,752.03	0.00
MED/SURG SUPPLY	319,970.29	4,070.72	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,687,469.72	6,427.36	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	279,740.17	1,836.12	OTHER THERAPEUTIC SVC	0.00	939.60
CT SCAN	308,416.75	671,122.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	115,290.18	2,478.18	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	175,292.79	0.00	MRI SERVICES	103,671.52	0.00
IV THERAPY	118,888.52	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	979,080.78	1,466.54	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	137,279.71	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	902,957.99	19,337.58	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	187,061.99	0.00	AMBULANCE	0.00	0.00
GI SERVICES	58,640.11	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	499,093.91	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	38,952.86	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	49,975.28	0.00	INJECTABLE DRUGS	2,132,409.55	8,920.57
RADIOLOGY THERAPEUTIC	135,662.20	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,934.92	197.75	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	126.78	674.99	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	623,685.76	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	71,529.31	12,802.78			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	38,747.22	4,550.52			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	111,997.86	13,780.65			
AUDIOLOGY	8,021.75	0.00			
CARDIOLOGY	400,058.24	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,057.82	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,409.76	0.00			
			TOTAL ANCILLARY	9,942,361.11	749,369.81
			TOTAL ACCOMODATIONS	1,556,366.99	27,647.52
			TOTAL CHARGES	11,498,728.10	777,017.33

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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GORDON HOSPITAL
 1035 RED BUD RD NE
 CALHOUN,GA 30701-2082

PROVIDER NUMBER
 000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,584.18	ADJUSTMENTS	0.00
COVERED CHARGES	7,550.82	CONTRACTUAL ALLOW	3,834.15
NON-COVERD CHARGES	33.36	TOTAL MEDICAID LIAB	3,716.67
		LESS: COB	3,716.67
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2		0	1,144.00		33.36
ROUTINE NURSERY	0		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	1,144.00		33.36
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	1,144.00		33.36

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

GORDON HOSPITAL
 1035 RED BUD RD NE
 CALHOUN,GA 30701-2082

PROVIDER NUMBER
 000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	643.15	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	349.47	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	227.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,334.39	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,151.38	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	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	700.68	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,406.82	0.00
			TOTAL ACCOMODATIONS	1,144.00	33.36
			TOTAL CHARGES	7,550.82	33.36

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:19:43
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GORDON HOSPITAL
1035 RED BUD RD NE
CALHOUN,GA 30701-2082

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,049,288.06	ADJUSTMENTS	274,563.04
COVERED CHARGES	13,662,281.66	CONTRACTUAL ALLOW	11,677,636.75
NON-COVERD CHARGES	1,387,006.40	TOTAL MEDICAID LIAB	1,984,644.91
		LESS: COB	2,533.67
		LESS: COPAYMENT	5,296.13
		REIMBURSEMENT	1,976,815.11
		ALL OTHER	1,782,261.91
		FEE SCHEDULE-LAB	169,373.51
		INJECTABLE DRUGS	25,179.69

TOTAL NUMBER OF CLAIMS 5,238

GORDON HOSPITAL
 1035 RED BUD RD NE
 CALHOUN, GA 30701-2082

PROVIDER NUMBER
 000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	146,608.53	31,808.01	OTHER LAB	54,540.01	0.00
MED/SURG SUPPLY	326,852.17	1,811.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	710,903.52	22,466.07	OTHER THERAPEUTIC SVC	0.00	31,260.81
CT SCAN	2,468,777.85	267,628.93	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	292,036.73	20,490.26	FEE SCHEDULE LAB	2,241,894.22	499,635.93
EKG/ECG	183,037.86	6,788.88	MRI SERVICES	647,521.29	43,290.33
IV THERAPY	283,879.64	18,929.66	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	936,123.49	114,203.05	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	11,633.80	234.53	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	37,263.25	3,634.41	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	223,544.55	2,848.90	AMBULANCE	0.00	0.00
GI SERVICES	114,857.97	18,325.83	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,966,622.27	8,209.71	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	78,306.31	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	434,355.72	115,393.53
RADIOLOGY THERAPEUTIC	103,209.74	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	894.89	197.75	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	47,682.13	3,224.60	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	80,943.19	68,728.81
LITHOTRIPSY	77,943.30	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	350,746.91	21,257.83			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	19,251.32	32,784.96			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	381,978.24	39,793.29			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	179,698.52	13,905.80			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	174,369.18	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	86,805.06	152.62			
			TOTAL ANCILLARY	13,662,281.66	1,387,006.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,662,281.66	1,387,006.40

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GORDON HOSPITAL
1035 RED BUD RD NE
CALHOUN,GA 30701-2082

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	100,847.30	ADJUSTMENTS	0.00
COVERED CHARGES	80,215.02	CONTRACTUAL ALLOW	64,576.81
NON-COVERD CHARGES	20,632.28	TOTAL MEDICAID LIAB	15,638.21
		LESS: COB	15,623.21
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 42

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GORDON HOSPITAL
 1035 RED BUD RD NE
 CALHOUN,GA 30701-2082

PROVIDER NUMBER
 000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	338.54	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,676.28	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,268.66	0.00	OTHER THERAPEUTIC SVC	0.00	891.56
CT SCAN	8,884.22	3,303.38	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,726.20	2,058.85
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,726.99	197.30	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	6,811.95	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	207.75	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,362.70	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	34,296.37	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	492.08	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,531.74	2,504.42
RADIOLOGY THERAPEUTIC	647.20	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,056.29	4,864.82			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	80,215.02	20,632.28
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	80,215.02	20,632.28

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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GORDON HOSPITAL
1035 RED BUD RD NE
CALHOUN,GA 30701-2082

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	603,520.19	ADJUSTMENTS	1,090.73
COVERED CHARGES	575,217.70	CONTRACTUAL ALLOW	546,464.55
NON-COVERD CHARGES	28,302.49	TOTAL MEDICAID LIAB	28,753.15
		LESS: COB	0.00
		LESS: COPAYMENT	1,068.00
		REIMBURSEMENT	27,685.15
		TOTAL NUMBER OF CLAIMS	514

Report : CLM-0808-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

GORDON HOSPITAL
 1035 RED BUD RD NE
 CALHOUN,GA 30701-2082

PROVIDER NUMBER
 000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,102.80	486.56	OTHER LAB	7,473.32	0.00
MED/SURG SUPPLY	1,362.58	118.79	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,291.69	363.08	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,182.08	3,303.38	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	66,738.89	14,783.37
EKG/ECG	3,879.36	0.00	MRI SERVICES	12,979.62	4,475.02
IV THERAPY	28,838.15	728.47	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,340.79	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	371,697.15	1,256.65	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	15,595.06	1,440.44
RADIOLOGY THERAPEUTIC	14,115.16	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,621.05	1,346.73			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	575,217.70	28,302.49
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	575,217.70	28,302.49

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GORDON HOSPITAL
1035 RED BUD RD NE
CALHOUN,GA 30701-2082

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,069.48	ADJUSTMENTS	0.00
COVERED CHARGES	17,993.06	CONTRACTUAL ALLOW	15,535.35
NON-COVERD CHARGES	76.42	TOTAL MEDICAID LIAB	2,457.71
		LESS: COB	2,448.71
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GORDON HOSPITAL
 1035 RED BUD RD NE
 CALHOUN,GA 30701-2082

PROVIDER NUMBER
 000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	550.00	0.00	OTHER LAB	1,147.96	0.00
MED/SURG SUPPLY	48.12	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,757.88	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,488.08	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,750.82	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	406.68	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,627.83	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	215.69	76.42
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	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	17,993.06	76.42
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,993.06	76.42

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GORDON HOSPITAL
1035 RED BUD RD NE
CALHOUN,GA 30701-2082

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	775,009.83	ADJUSTMENTS	22,434.24
COVERED CHARGES	753,873.34	CONTRACTUAL ALLOW	660,142.04
NON-COVERD CHARGES	21,136.49	TOTAL MEDICAID LIAB	93,731.30
		LESS: COB	0.00
		LESS: COPAYMENT	141.00
		REIMBURSEMENT	93,590.30

TOTAL NUMBER OF CLAIMS 17

Report : CLM-0812-0
 Process : CLMJ0800
 Location: CLMP8000

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

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SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GORDON HOSPITAL
 1035 RED BUD RD NE
 CALHOUN,GA 30701-2082

PROVIDER NUMBER
 000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,264.27	1,654.57	OTHER LAB	2,295.92	0.00
MED/SURG SUPPLY	41,109.07	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,054.20	3,097.65	OTHER THERAPEUTIC SVC	0.00	445.78
CT SCAN	40,048.58	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,183.20	1,656.09
EKG/ECG	1,939.68	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	801.29	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	174,533.76	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,912.21	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	34,334.22	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,744.25	672.86	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,483.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,867.30	2,210.42
RADIOLOGY THERAPEUTIC	338,989.27	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	126.78	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	57,670.39	11,272.34
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,079.44	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	562.54	0.00			
			TOTAL ANCILLARY	753,873.34	21,136.49
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	753,873.34	21,136.49

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GORDON HOSPITAL
1035 RED BUD RD NE
CALHOUN,GA 30701-2082

PROVIDER NUMBER
000000833A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,376,627.40	ADJUSTMENTS	139,657.83
COVERED CHARGES	1,355,422.40	CONTRACTUAL ALLOW	712,956.16
NON-COVERD CHARGES	21,205.00	TOTAL MEDICAID LIAB	642,466.24
		LESS: COB	159.75
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	642,306.49

TOTAL NUMBER OF ADMISSIONS 177

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	343		0	191,394.00		21,205.00
ROUTINE NURSERY	119		0	56,287.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	462		0	247,681.00		21,205.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	11		0	15,279.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	11		0	15,279.00		0.00
TOTAL ACCOMODATIONS	473		0	262,960.00		21,205.00

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	218,564.40	0.00	OTHER LAB	3,262.00	0.00
MED/SURG SUPPLY	89,464.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	243,500.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	31,510.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	72,726.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,600.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,516.00	0.00	MRI SERVICES	13,878.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	74,775.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	183,220.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	47,015.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,592.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,120.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	34,537.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,184.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,933.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,116.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	13,472.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,086.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,031.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	5,103.00	0.00			
CARDIOLOGY	8,264.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,994.00	0.00			
			TOTAL ANCILLARY	1,092,462.40	0.00
			TOTAL ACCOMODATIONS	262,960.00	21,205.00
			TOTAL CHARGES	1,355,422.40	21,205.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,665,740.60	ADJUSTMENTS	118,596.16
COVERED CHARGES	2,433,632.47	CONTRACTUAL ALLOW	1,811,588.87
NON-COVERD CHARGES	232,108.13	TOTAL MEDICAID LIAB	622,043.60
		LESS: COB	960.07
		LESS: COPAYMENT	3,033.00
		REIMBURSEMENT	618,050.53
		ALL OTHER	538,656.75
		FEE SCHEDULE-LAB	70,020.61
		INJECTABLE DRUGS	9,373.17
		TOTAL NUMBER OF CLAIMS	2,250

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,352.00	15.00	OTHER LAB	9,746.00	0.00
MED/SURG SUPPLY	140,490.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	170,616.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	290,030.00	36,142.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	71,611.00	28,977.00	FEE SCHEDULE LAB	492,024.80	86,374.70
EKG/ECG	7,998.00	146.00	MRI SERVICES	42,335.00	1,292.00
IV THERAPY	130,115.00	7,874.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	339,131.57	15,930.43	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,018.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	21,380.00	2,228.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	38,314.00	522.00	AMBULANCE	0.00	0.00
GI SERVICES	53,719.00	2,721.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	278,385.00	700.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	68,001.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	76,181.60	20,779.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	20,087.00	21,243.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	215.00	1,075.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	83.00	245.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	19,051.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	63,006.00	3,002.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,985.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,970.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	49,787.00	2,842.00			
			TOTAL ANCILLARY	2,433,632.47	232,108.13
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,433,632.47	232,108.13

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,793.00	ADJUSTMENTS	0.00
COVERED CHARGES	9,427.00	CONTRACTUAL ALLOW	3,458.80
NON-COVERD CHARGES	366.00	TOTAL MEDICAID LIAB	5,968.20
		LESS: COB	5,968.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 14

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 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	528.00	0.00
MED/SURG SUPPLY	98.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	845.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,293.00	16.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	690.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,157.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,270.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	161.00	350.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,385.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,427.00	366.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,427.00	366.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	100,960.00	ADJUSTMENTS	264.70
COVERED CHARGES	89,578.00	CONTRACTUAL ALLOW	79,117.22
NON-COVERD CHARGES	11,382.00	TOTAL MEDICAID LIAB	10,460.78
		LESS: COB	0.00
		LESS: COPAYMENT	330.00
		REIMBURSEMENT	10,130.78
		TOTAL NUMBER OF CLAIMS	187

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	285.00	10.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,786.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,907.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,134.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	3,405.00	FEE SCHEDULE LAB	19,425.00	2,600.00
EKG/ECG	270.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,180.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,628.00	538.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	44,182.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,327.00	1,693.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	3,136.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,454.00	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	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	89,578.00	11,382.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	89,578.00	11,382.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	62,283.00	ADJUSTMENTS	10,396.89
COVERED CHARGES	61,445.00	CONTRACTUAL ALLOW	45,501.88
NON-COVERD CHARGES	838.00	TOTAL MEDICAID LIAB	15,943.12
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	15,934.12

TOTAL NUMBER OF CLAIMS 3

Report : CLM-0812-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,220.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	18,805.00	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	88.00	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	24,648.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	84.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,760.00	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	3,166.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	700.00	838.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	10,974.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	61,445.00	838.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	61,445.00	838.00

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

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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	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:20:38
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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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	458,116,119.36	ADJUSTMENTS	40,882,289.71
COVERED CHARGES	428,149,341.19	CONTRACTUAL ALLOW	306,698,385.13
NON-COVERD CHARGES	29,966,778.17	TOTAL MEDICAID LIAB	121,450,956.06
		LESS: COB	380,129.14
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	121,070,826.92

TOTAL NUMBER OF ADMISSIONS 8,249

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	31,391		87	43,971,161.00		12,473,623.00
ROUTINE NURSERY	7,008		9	14,745,526.00		1,749,888.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	38,399		96	58,716,687.00		14,223,511.00
SPECIAL CARE SERVICES						
CCU	315		0	965,524.00		79,000.00
ICU	14,166		0	57,592,944.00		1,227,322.00
NICU	730		0	3,836,055.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	10		0	31,250.00		0.00
BURN UNIT	203		0	1,604,309.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	15,424		0	64,030,082.00		1,306,322.00
TOTAL ACCOMODATIONS	53,823		96	122,746,769.00		15,529,833.00

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,139,580.45	281,395.38	OTHER LAB	1,930,484.00	9,518.00
MED/SURG SUPPLY	12,349,177.93	1,224,145.79	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	50,800,152.65	878,353.39	EDUCATION & TRAINING	430.00	0.00
RADIOLOGY-DIAGNOSTIC	10,051,213.50	69,746.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,301,257.00	5,186,557.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,882,614.54	176,082.03	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,504,079.00	10,505.00	MRI SERVICES	4,179,156.00	21,427.00
IV THERAPY	345,838.41	11,342.00	PROFESSIONAL FEES	0.00	1,003.00
OPERATING ROOM	73,888,320.71	1,541,007.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,453,655.60	10,002.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	37,149,573.00	524,062.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,599,244.00	121,999.00	AMBULANCE	0.00	1,208.00
GI SERVICES	999,409.00	39,016.00	CAST ROOM	10,064.00	1,823.00
EMERGENCY ROOM	13,841,805.00	239,081.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,430,232.00	25,620.00	DRUG-SPECIFIC/HOME IV	0.00	1,736.26
LABORATORY PATHOLOGIC	1,149,633.00	21,322.60	INJECTABLE DRUGS	14,056,074.32	297,329.87
RADIOLOGY THERAPEUTIC	923,398.00	76,538.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,699,126.34	65,097.05	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,612,345.54	36,629.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	828,073.00	36,641.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,910.00	386,192.00	TRAUMA RESPONSE	0.00	1,263,289.00
PSYCHIATRIC SERVICES	226,210.00	0.00	IMPL DEV CHARGE PATIENTS	5,858,228.98	147,193.74
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	19,076.62
OTHER IMAGING SERVICE	2,016,370.00	488,951.00			
BLOOD	181,990.00	0.00			
BLOOD STORAGE & PRO.	7,674,847.22	639,045.52			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,010,536.00	386,457.92			
AUDIOLOGY	515,206.00	236.00			
CARDIOLOGY	5,508,006.00	175,860.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,187,267.00	1,960.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,095,064.00	19,497.00			
			TOTAL ANCILLARY	305,402,572.19	14,436,945.17
			TOTAL ACCOMODATIONS	122,746,769.00	15,529,833.00
			TOTAL CHARGES	428,149,341.19	29,966,778.17

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:20:38
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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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
618	2014210000281	07/17/14 - 07/20/14	08/04/14	0.00	1,135.00	0.00	0.00	0.00
-1	9714241965076	06/03/14 - 06/05/14	09/08/14	0.00	0.00	0.00	0.00	0.00
3000	9814294000073	08/05/14 - 08/07/14	10/27/14	0.00	325.00	0.00	0.00	0.00
618	2014337007381	10/01/14 - 11/21/14	12/08/14	0.00	1,135.00	0.00	0.00	0.00
615	2015156078064	07/09/14 - 07/24/14	06/15/15	0.00	2,708.00	0.00	0.00	0.00
63	2215177002920	09/25/14 - 09/27/14	06/29/15	0.00	233.62	0.00	0.00	0.00
615	2015187022765	09/01/14 - 10/08/14	07/13/15	0.00	5,416.00	0.00	0.00	0.00
615	2015189093544	10/02/14 - 10/10/14	07/13/15	0.00	2,708.00	0.00	0.00	0.00
615	2215195009550	08/28/14 - 10/08/14	01/01/00	0.00	5,416.00	0.00	0.00	0.00
TOTAL				0.00	19,076.62	0.00	0.00	0.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:21:37
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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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,384,422.36	ADJUSTMENTS	0.00
COVERED CHARGES	1,338,069.36	CONTRACTUAL ALLOW	832,765.89
NON-COVERD CHARGES	46,353.00	TOTAL MEDICAID LIAB	505,303.47
		LESS: COB	505,303.47
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 16

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	68		0	98,464.00		22,981.00
ROUTINE NURSERY	2		0	5,405.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	70		0	103,869.00		22,981.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	35		0	162,700.00		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	35		0	162,700.00		0.00
TOTAL ACCOMODATIONS	105		0	266,569.00		22,981.00

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,586.24	0.00	OTHER LAB	4,143.00	0.00
MED/SURG SUPPLY	20,327.78	2,108.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	99,922.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	37,157.00	0.00	OTHER THERAPEUTIC SVC	0.00	269.00
CT SCAN	127,648.00	8,062.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,237.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,483.00	0.00	MRI SERVICES	19,408.00	0.00
IV THERAPY	1,713.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	376,273.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,242.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	36,020.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	80,835.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,186.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,828.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,698.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,340.00	0.00	INJECTABLE DRUGS	31,990.29	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	10,987.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,232.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	40.00	501.00	TRAUMA RESPONSE	0.00	11,696.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	26,311.05	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,730.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	80,245.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,272.00	736.00			
AUDIOLOGY	439.00	0.00			
CARDIOLOGY	6,207.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,071,500.36	23,372.00
			TOTAL ACCOMODATIONS	266,569.00	22,981.00
			TOTAL CHARGES	1,338,069.36	46,353.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	126,677,172.56	ADJUSTMENTS	1,798,471.90
COVERED CHARGES	111,771,666.90	CONTRACTUAL ALLOW	86,152,651.36
NON-COVERD CHARGES	14,905,505.66	TOTAL MEDICAID LIAB	25,619,015.54
		LESS: COB	33,380.43
		LESS: COPAYMENT	153,460.01
		REIMBURSEMENT	25,432,175.10
		ALL OTHER	21,353,560.01
		FEE SCHEDULE-LAB	2,099,798.43
		INJECTABLE DRUGS	1,978,816.66

TOTAL NUMBER OF CLAIMS 73,234

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	454,523.91	8,109.42	OTHER LAB	1,482,364.50	49,166.00
MED/SURG SUPPLY	457,680.76	201,031.23	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	4,082.00	EDUCATION & TRAINING	0.00	14,914.00
RADIOLOGY-DIAGNOSTIC	4,895,982.00	240,924.00	OTHER THERAPEUTIC SVC	0.00	2,148.00
CT SCAN	8,687,464.00	445,987.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	363,281.00	67,136.08	FEE SCHEDULE LAB	23,520,018.40	6,664,757.70
EKG/ECG	1,315,327.50	100,267.00	MRI SERVICES	2,289,598.00	118,359.00
IV THERAPY	2,470,995.00	223,263.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,066,208.34	1,045,922.82	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	215,853.00	2,294.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	815,582.00	108,631.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,198,247.00	67,471.00	AMBULANCE	0.00	0.00
GI SERVICES	1,071,341.84	197,091.00	CAST ROOM	8,963.00	0.00
EMERGENCY ROOM	20,072,733.50	153,569.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	489,942.00	1,290.00	DRUG-SPECIFIC/HOME IV	0.00	361.18
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,106,115.40	2,085,646.45
RADIOLOGY THERAPEUTIC	3,433,996.00	139,803.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	84,224.00	41,520.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	45,559.00	13,411.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	76,210.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	12,278,461.00	254,878.66	TRAUMA RESPONSE	0.00	366,783.00
PSYCHIATRIC SERVICES	528,300.00	135,926.00	IMPL DEV CHARGE PATIENTS	88,715.89	387,838.13
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,718,900.00	236,144.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	847,632.34	6,407.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,147,155.00	1,217,243.94			
AUDIOLOGY	43,417.00	8,348.00			
CARDIOLOGY	2,370,548.00	212,657.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	83,985.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,118,552.52	5,915.00			
			TOTAL ANCILLARY	111,771,666.90	14,905,505.66
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	111,771,666.90	14,905,505.66

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	460,713.23	ADJUSTMENTS	0.00
COVERED CHARGES	261,916.58	CONTRACTUAL ALLOW	123,718.76
NON-COVERD CHARGES	198,796.65	TOTAL MEDICAID LIAB	138,197.82
		LESS: COB	137,944.62
		LESS: COPAYMENT	253.20
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 156

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	723.37	0.00	OTHER LAB	2,138.00	0.00
MED/SURG SUPPLY	1,099.99	1,667.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	194.00
RADIOLOGY-DIAGNOSTIC	17,576.00	518.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,638.00	24,004.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,120.00	2,214.00	FEE SCHEDULE LAB	63,458.00	23,804.00
EKG/ECG	1,337.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	13,531.00	1,048.00	PROFESSIONAL FEES	0.00	74.00
OPERATING ROOM	14,148.00	60,051.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	903.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,170.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,200.00	31,030.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	49,440.00	1,601.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,949.66	3,992.65
RADIOLOGY THERAPEUTIC	2,466.00	39,111.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,208.00	1,610.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,038.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,350.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	18,996.00	164.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	743.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,259.00	742.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,697.56	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,142.00	412.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,758.00	4,467.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,920.00	0.00			
			TOTAL ANCILLARY	261,916.58	198,796.65
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	261,916.58	198,796.65

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,797,240.39	ADJUSTMENTS	946.92
COVERED CHARGES	2,660,002.47	CONTRACTUAL ALLOW	2,586,329.52
NON-COVERD CHARGES	137,237.92	TOTAL MEDICAID LIAB	73,672.95
		LESS: COB	0.00
		LESS: COPAYMENT	4,026.00
		REIMBURSEMENT	69,646.95
		TOTAL NUMBER OF CLAIMS	1,317

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,235.66	153.12	OTHER LAB	35,926.00	0.00
MED/SURG SUPPLY	1,567.00	1,267.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	209,825.00	6,768.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	147,749.00	4,560.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	341,327.00	82,873.00
EKG/ECG	26,358.00	1,146.00	MRI SERVICES	13,293.00	0.00
IV THERAPY	77,010.00	11,432.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,726.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,899.00	300.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,707,155.00	4,812.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,316.81	10,735.80
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	9,552.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	26,068.00	1,288.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	375.00	846.00	IMPL DEV CHARGE PATIENTS	0.00	143.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,748.00	1,362.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	513.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,586.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	30,325.00	0.00			
			TOTAL ANCILLARY	2,660,002.47	137,237.92
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,660,002.47	137,237.92

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2.50	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	1,904.00	692.00
EKG/ECG	191.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	541.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,817.00	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	45.00	30.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,500.50	722.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,500.50	722.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,554,214.56	ADJUSTMENTS	483,552.07
COVERED CHARGES	16,825,298.20	CONTRACTUAL ALLOW	13,862,688.04
NON-COVERD CHARGES	728,916.36	TOTAL MEDICAID LIAB	2,962,610.16
		LESS: COB	0.01
		LESS: COPAYMENT	5,220.00
		REIMBURSEMENT	2,957,390.15

TOTAL NUMBER OF CLAIMS 347

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	58,349.30	22.32	OTHER LAB	1,166.00	0.00
MED/SURG SUPPLY	162,649.84	50,122.32	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	76,495.00	22,487.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,683.00	2,975.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,258.00	FEE SCHEDULE LAB	172,492.00	20,766.00
EKG/ECG	1,337.00	191.00	MRI SERVICES	9,317.00	2,708.00
IV THERAPY	86,408.00	1,169.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,347,923.60	91,591.41	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	44,596.00	1,800.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,306,841.00	5,944.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,833.00	215.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	353,379.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	864,699.77	77,100.30
RADIOLOGY THERAPEUTIC	6,512,658.00	162,337.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	907.00	1,413.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,038.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	9,125.00	613.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	464,777.69	84,895.01
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,030.00	2,289.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	10,472.00	10,404.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	273,233.00	188,616.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,088.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	27,800.00	0.00			
			TOTAL ANCILLARY	16,825,298.20	728,916.36
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,825,298.20	728,916.36

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:26:24
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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	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

SPALDING REGIONAL HOSPITAL
 601 S 8TH ST
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER 000000866A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	38,569,533.19	ADJUSTMENTS	1,289,514.21
COVERED CHARGES	37,805,347.02	CONTRACTUAL ALLOW	31,393,336.03
NON-COVERD CHARGES	764,186.17	TOTAL MEDICAID LIAB	6,412,010.99
		LESS: COB	64,292.17
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,347,718.82

TOTAL NUMBER OF ADMISSIONS 794

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,088		29	3,318,847.50		278,384.65
ROUTINE NURSERY	113		2	87,472.00		1,881.80
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,201		31	3,406,319.50		280,266.45
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	712		0	1,445,137.50		0.00
NICU	2		0	3,980.25		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	714		0	1,449,117.75		0.00
TOTAL ACCOMODATIONS	3,915		31	4,855,437.25		280,266.45

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

SPALDING REGIONAL HOSPITAL
 601 S 8TH ST
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,337,893.42	19,034.68	OTHER LAB	151,076.30	0.00
MED/SURG SUPPLY	4,040,980.92	17,237.24	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,426,808.38	14,139.30	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	796,056.75	1,662.15	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,012,599.55	5,565.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	136,709.98	1,502.55	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	265,652.95	0.00	MRI SERVICES	397,566.65	0.00
IV THERAPY	3,340.10	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,350,178.29	2,163.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	168,650.90	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,699,776.68	6,745.65	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	561,753.05	0.00	AMBULANCE	0.00	0.00
GI SERVICES	153,172.80	1,296.75	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,420,970.70	1,025.85	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	160,329.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	145,885.53	0.00	INJECTABLE DRUGS	22.49	0.00
RADIOLOGY THERAPEUTIC	62,707.10	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	17,665.12	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	33,248.49	645.75	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	259,133.00	0.00	PATIENT CONVENIENCE	0.00	145.45
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	21,414.50	115.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	359,899.81	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	132,957.75	5,114.55			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	406,632.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	249,620.99	0.00			
AUDIOLOGY	9,448.15	0.00			
CARDIOLOGY	1,261,607.22	893.55			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	25,263.20	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	287,519.40	0.00			
			TOTAL ANCILLARY	32,949,909.77	483,919.72
			TOTAL ACCOMODATIONS	4,855,437.25	280,266.45
			TOTAL CHARGES	37,805,347.02	764,186.17

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

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

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SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

SPALDING REGIONAL HOSPITAL
 601 S 8TH ST
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	31,000.04	ADJUSTMENTS	0.00
COVERED CHARGES	30,892.54	CONTRACTUAL ALLOW	24,956.43
NON-COVERD CHARGES	107.50	TOTAL MEDICAID LIAB	5,936.11
		LESS: COB	5,936.11
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2		0	2,150.00		107.50
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2		0	2,150.00		107.50
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	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	2		0	2,150.00		107.50

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

SPALDING REGIONAL HOSPITAL
 601 S 8TH ST
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,174.92	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,058.87	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,103.15	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	5,335.05	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,086.85	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	1,408.05	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	760.20	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	115.50	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	1,584.45	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	115.50	0.00			
			TOTAL ANCILLARY	28,742.54	0.00
			TOTAL ACCOMODATIONS	2,150.00	107.50
			TOTAL CHARGES	30,892.54	107.50

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:26:50
Page: 5

SPALDING REGIONAL HOSPITAL
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,360,684.04	ADJUSTMENTS	808,871.23
COVERED CHARGES	24,417,787.81	CONTRACTUAL ALLOW	21,057,376.46
NON-COVERD CHARGES	2,942,896.23	TOTAL MEDICAID LIAB	3,360,411.35
		LESS: COB	2,817.81
		LESS: COPAYMENT	6,543.88
		REIMBURSEMENT	3,351,049.66
		ALL OTHER	3,035,727.32
		FEE SCHEDULE-LAB	245,553.73
		INJECTABLE DRUGS	69,768.61

TOTAL NUMBER OF CLAIMS 7,027

SPALDING REGIONAL HOSPITAL
 601 S 8TH ST
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	755,882.04	19,073.56	OTHER LAB	199,247.90	0.00
MED/SURG SUPPLY	1,546,361.83	31,130.71	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,480,885.84	23,051.20	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,075,353.70	679,258.65	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	13,000.10	5,932.04	FEE SCHEDULE LAB	4,102,769.40	836,473.40
EKG/ECG	482,813.85	13,329.15	MRI SERVICES	214,154.26	20,862.45
IV THERAPY	571,444.70	38,560.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	877,450.29	103,153.17	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	473,401.24	106,531.18	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	489,112.75	7,127.40	AMBULANCE	0.00	0.00
GI SERVICES	91,946.35	17,649.30	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,020,246.00	64,100.90	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	111,602.50	2,611.35	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,326,864.09	413,445.09
RADIOLOGY THERAPEUTIC	37,854.46	1,738.80	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,748.30	12,444.95	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,079.50	2,858.44	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	12,001.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	405,430.52	132,919.02	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	81,507.99	26,535.17
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	452,023.75	94,591.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	65,712.95			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	287,660.80	21,140.00			
AUDIOLOGY	200.00	0.00			
CARDIOLOGY	400,265.50	108,819.35			
AMBULATORY SURGERY	12,952.55	282.45			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	461,033.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	437,494.10	81,562.55			
			TOTAL ANCILLARY	24,417,787.81	2,942,896.23
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	24,417,787.81	2,942,896.23

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SPALDING REGIONAL HOSPITAL
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	53,713.76	ADJUSTMENTS	0.00
COVERED CHARGES	46,116.68	CONTRACTUAL ALLOW	38,583.56
NON-COVERD CHARGES	7,597.08	TOTAL MEDICAID LIAB	7,533.12
		LESS: COB	7,525.81
		LESS: COPAYMENT	7.31
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 15

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SPALDING REGIONAL HOSPITAL
 601 S 8TH ST
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	780.87	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,226.48	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,096.70	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,925.00	2,658.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,669.39	1,328.55
EKG/ECG	1,752.30	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	830.75	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	185.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,537.30	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	932.44	516.63
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	1,182.30	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,690.50	1,749.30			
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	307.65	1,344.00			
			TOTAL ANCILLARY	46,116.68	7,597.08
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	46,116.68	7,597.08

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

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SPALDING REGIONAL HOSPITAL
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,261,759.47	ADJUSTMENTS	1,759.01
COVERED CHARGES	1,205,634.03	CONTRACTUAL ALLOW	1,161,359.30
NON-COVERD CHARGES	56,125.44	TOTAL MEDICAID LIAB	44,274.73
		LESS: COB	0.00
		LESS: COPAYMENT	1,602.00
		REIMBURSEMENT	42,672.73
		TOTAL NUMBER OF CLAIMS	792

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

SPALDING REGIONAL HOSPITAL
 601 S 8TH ST
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,584.16	26.74	OTHER LAB	8,963.85	0.00
MED/SURG SUPPLY	20,746.89	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	86,612.35	1,316.55	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	55,752.75	13,055.70	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	178,406.27	24,569.70
EKG/ECG	15,369.90	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	43,043.90	551.25	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	5,314.45	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	679,185.05	433.65	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	63,492.41	4,999.30
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	765.05	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	18,465.60	11,172.55			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,963.10	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,202.10	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,766.20	0.00			
			TOTAL ANCILLARY	1,205,634.03	56,125.44
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,205,634.03	56,125.44

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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SPALDING REGIONAL HOSPITAL
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,608.75	ADJUSTMENTS	0.00
COVERED CHARGES	3,608.75	CONTRACTUAL ALLOW	2,811.87
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	796.88
		LESS: COB	796.88
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SPALDING REGIONAL HOSPITAL
 601 S 8TH ST
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,084.20	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	147.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,076.95	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	300.60	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	3,608.75	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,608.75	0.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SPALDING REGIONAL HOSPITAL
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	764,149.32	ADJUSTMENTS	32,781.12
COVERED CHARGES	677,378.21	CONTRACTUAL ALLOW	578,026.13
NON-COVERD CHARGES	86,771.11	TOTAL MEDICAID LIAB	99,352.08
		LESS: COB	0.00
		LESS: COPAYMENT	79.79
		REIMBURSEMENT	99,272.29
		TOTAL NUMBER OF CLAIMS	18

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SPALDING REGIONAL HOSPITAL
 601 S 8TH ST
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,416.57	1,983.72	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	136,761.70	1,741.07	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,992.59	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,308.40	2,658.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	33,493.16	5,682.15
EKG/ECG	4,669.20	972.30	MRI SERVICES	0.00	0.00
IV THERAPY	1,845.50	320.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	116,696.08	35,044.52	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,680.30	369.80	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	58,133.80	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,153.65	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,493.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	100,729.90	19,876.53
RADIOLOGY THERAPEUTIC	9,607.50	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	471.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	58,629.26	262.67
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,611.70	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	44,177.70	17,388.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,977.60	0.00			
			TOTAL ANCILLARY	677,378.21	86,771.11
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	677,378.21	86,771.11

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SPALDING REGIONAL HOSPITAL
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:27:30
 Page: 1

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

HABERSHAM COUNTY MEDICAL CTR
 541 CENTRAL AVE
 DEMOREST,GA 30535-5531

PROVIDER NUMBER 000000877A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,334,232.34	ADJUSTMENTS	221,396.48
COVERED CHARGES	2,312,553.15	CONTRACTUAL ALLOW	1,130,405.97
NON-COVERD CHARGES	21,679.19	TOTAL MEDICAID LIAB	1,182,147.18
		LESS: COB	17,506.96
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,164,640.22

TOTAL NUMBER OF ADMISSIONS 280

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	485		9	222,180.00		4,440.00
ROUTINE NURSERY	181		1	54,940.00		860.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	666		10	277,120.00		5,300.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	66		1	72,600.00		1,100.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	66		1	72,600.00		1,100.00
TOTAL ACCOMODATIONS	732		11	349,720.00		6,400.00

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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 Page: 2

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

HABERSHAM COUNTY MEDICAL CTR
 541 CENTRAL AVE
 DEMOREST,GA 30535-5531

PROVIDER NUMBER
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	168,407.23	0.00	OTHER LAB	10,252.25	0.00
MED/SURG SUPPLY	161,018.40	504.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	253,097.75	59.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,307.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	90,527.50	521.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,882.83	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	10,961.00	0.00	MRI SERVICES	9,032.25	0.00
IV THERAPY	281,791.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	107,964.50	2,181.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	282,761.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	36,033.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	43,302.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	106,798.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	78,203.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	4,406.00	0.00	INJECTABLE DRUGS	30,762.52	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	180.75	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,922.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	209.19
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	14,229.25	254.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	130,403.42	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,838.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	17,584.75	11,550.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,692.25	0.00			
AUDIOLOGY	19,134.75	0.00			
CARDIOLOGY	15,757.50	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	32,579.25	0.00			
			TOTAL ANCILLARY	1,962,833.15	15,279.19
			TOTAL ACCOMODATIONS	349,720.00	6,400.00
			TOTAL CHARGES	2,312,553.15	21,679.19

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

HABERSHAM COUNTY MEDICAL CTR
 541 CENTRAL AVE
 DEMOREST,GA 30535-5531

PROVIDER NUMBER
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,724.74	ADJUSTMENTS	0.00
COVERED CHARGES	23,724.74	CONTRACTUAL ALLOW	11,436.79
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	12,287.95
		LESS: COB	12,287.95
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	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

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

HABERSHAM COUNTY MEDICAL CTR
 541 CENTRAL AVE
 DEMOREST,GA 30535-5531

PROVIDER NUMBER
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,731.03	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	304.96	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,808.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	204.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	939.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	184.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	2,201.00	0.00
IV THERAPY	8,239.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,026.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,006.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,320.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	20,964.74	0.00
			TOTAL ACCOMODATIONS	2,760.00	0.00
			TOTAL CHARGES	23,724.74	0.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:27:32
Page: 5

HABERSHAM COUNTY MEDICAL CTR
541 CENTRAL AVE
DEMOREST,GA 30535-5531

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,485,364.69	ADJUSTMENTS	122,216.59
COVERED CHARGES	3,199,884.10	CONTRACTUAL ALLOW	2,418,695.20
NON-COVERD CHARGES	285,480.59	TOTAL MEDICAID LIAB	781,188.90
		LESS: COB	1,413.78
		LESS: COPAYMENT	1,315.60
		REIMBURSEMENT	778,459.52
		ALL OTHER	690,784.66
		FEE SCHEDULE-LAB	74,058.78
		INJECTABLE DRUGS	13,616.08
		TOTAL NUMBER OF CLAIMS	2,691

HABERSHAM COUNTY MEDICAL CTR
 541 CENTRAL AVE
 DEMOREST,GA 30535-5531

PROVIDER NUMBER
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	69,690.22	1,896.05	OTHER LAB	75,065.50	0.00
MED/SURG SUPPLY	137,404.40	438.24	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	250.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	142,203.50	1,340.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	443,294.25	85,822.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,983.25	4,827.58	FEE SCHEDULE LAB	556,045.40	94,853.15
EKG/ECG	39,931.75	4,068.00	MRI SERVICES	91,278.50	9,335.50
IV THERAPY	45,046.25	8,922.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	108,263.08	15,901.83	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,172.50	225.50	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	17,523.62	1,727.13	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	55,427.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,142,627.13	10,336.12	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	49,589.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	45,550.75	8,904.69
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,071.25	2,117.25	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	199.50	0.02	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	13.68
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	17,144.75	3,052.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	17,363.50	6,239.10
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	41,586.50	4,295.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,777.50	1,050.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	39,984.25	500.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	15,678.00	18,575.50			
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	39,982.50	788.50			
			TOTAL ANCILLARY	3,199,884.10	285,480.59
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,199,884.10	285,480.59

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:27:41
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HABERSHAM COUNTY MEDICAL CTR
541 CENTRAL AVE
DEMOREST,GA 30535-5531

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	62,599.12	ADJUSTMENTS	0.00
COVERED CHARGES	52,145.92	CONTRACTUAL ALLOW	24,189.36
NON-COVERD CHARGES	10,453.20	TOTAL MEDICAID LIAB	27,956.56
		LESS: COB	27,953.56
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 33

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HABERSHAM COUNTY MEDICAL CTR
 541 CENTRAL AVE
 DEMOREST,GA 30535-5531

PROVIDER NUMBER
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,415.08	129.40	OTHER LAB	4,431.00	0.00
MED/SURG SUPPLY	4,246.59	507.45	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,025.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	4,598.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,256.25	1,159.00
EKG/ECG	113.00	226.00	MRI SERVICES	0.00	0.00
IV THERAPY	459.50	234.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,530.75	1,506.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	77.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,521.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,841.75	487.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,034.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	717.05	292.10
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	82.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	701.20	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,414.25	1,153.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,940.75	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	456.50	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	2,040.50	0.00			
			TOTAL ANCILLARY	52,145.92	10,453.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	52,145.92	10,453.20

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:27:41
Page: 9

HABERSHAM COUNTY MEDICAL CTR
541 CENTRAL AVE
DEMOREST,GA 30535-5531

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	140,955.26	ADJUSTMENTS	167.82
COVERED CHARGES	139,833.91	CONTRACTUAL ALLOW	126,520.19
NON-COVERD CHARGES	1,121.35	TOTAL MEDICAID LIAB	13,313.72
		LESS: COB	0.00
		LESS: COPAYMENT	501.00
		REIMBURSEMENT	12,812.72
		TOTAL NUMBER OF CLAIMS	238

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

HABERSHAM COUNTY MEDICAL CTR
 541 CENTRAL AVE
 DEMOREST,GA 30535-5531

PROVIDER NUMBER
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,883.39	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	92.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,659.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,533.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	184.00	FEE SCHEDULE LAB	15,536.50	738.00
EKG/ECG	1,017.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	463.50	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	106,986.25	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	1,338.52	37.35
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	324.00	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	0.00	0.00			
			TOTAL ANCILLARY	139,833.91	1,121.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	139,833.91	1,121.35

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:27:42
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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HABERSHAM COUNTY MEDICAL CTR
541 CENTRAL AVE
DEMOREST,GA 30535-5531

PROVIDER NUMBER
000000877A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,557.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,557.00	CONTRACTUAL ALLOW	1,930.82
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1,626.18
		LESS: COB	1,620.18
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	6

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HABERSHAM COUNTY MEDICAL CTR
 541 CENTRAL AVE
 DEMOREST,GA 30535-5531

PROVIDER NUMBER
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5.50	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	271.75	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	709.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	77.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,328.50	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	3.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	162.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,557.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,557.00	0.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HABERSHAM COUNTY MEDICAL CTR
541 CENTRAL AVE
DEMOREST,GA 30535-5531

PROVIDER NUMBER
000000877A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:27:43
Page: 14

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HABERSHAM COUNTY MEDICAL CTR
541 CENTRAL AVE
DEMOREST,GA 30535-5531

PROVIDER NUMBER
000000877A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:27:51
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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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	108,760,699.36	ADJUSTMENTS	6,688,125.06
COVERED CHARGES	104,910,129.36	CONTRACTUAL ALLOW	77,922,600.75
NON-COVERD CHARGES	3,850,570.00	TOTAL MEDICAID LIAB	26,987,528.61
		LESS: COB	214,156.46
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	26,773,372.15

TOTAL NUMBER OF ADMISSIONS 3,110

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	10,436		2	8,536,501.00		2,587,838.00
ROUTINE NURSERY	2,411		0	1,638,672.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	12,847		2	10,175,173.00		2,587,838.00
SPECIAL CARE SERVICES						
CCU	990		0	1,931,587.00		1,963.00
ICU	1,438		0	2,868,544.00		0.00
NICU	348		0	543,751.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		245	0.00		225,968.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,776		245	5,343,882.00		227,931.00
TOTAL ACCOMODATIONS	15,623		247	15,519,055.00		2,815,769.00

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,149,213.32	68,138.00	OTHER LAB	520,685.00	6,275.00
MED/SURG SUPPLY	7,678,891.54	213,703.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,520,388.71	79,240.00	EDUCATION & TRAINING	480.00	0.00
RADIOLOGY-DIAGNOSTIC	1,150,149.00	750.00	OTHER THERAPEUTIC SVC	70,092.00	0.00
CT SCAN	3,399,572.00	10,404.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	416,786.00	9,109.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	556,698.00	1,100.00	MRI SERVICES	800,984.00	2,408.00
IV THERAPY	671,723.00	26,137.00	PROFESSIONAL FEES	0.00	1,504.00
OPERATING ROOM	8,710,636.00	36,196.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,820,478.00	2,649.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,001,996.00	64,025.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,878,935.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,157,688.00	6,843.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,398,090.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	373,686.00	626.00	INJECTABLE DRUGS	9,797,212.79	236,400.00
RADIOLOGY THERAPEUTIC	193,229.00	1,383.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	190,819.00	6,721.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	155,860.00	1,977.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	510,686.00	48,617.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	27,176.00	610.00	TRAUMA RESPONSE	0.00	28,000.00
PSYCHIATRIC SERVICES	0.00	2,948.00	IMPL DEV CHARGE PATIENTS	5,549,902.00	976.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	516,928.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	671,458.00	95,672.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	315,329.00	77,511.00			
AUDIOLOGY	100,942.00	0.00			
CARDIOLOGY	2,634,978.00	3,850.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	144,498.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	304,885.00	1,029.00			
			TOTAL ANCILLARY	89,391,074.36	1,034,801.00
			TOTAL ACCOMODATIONS	15,519,055.00	2,815,769.00
			TOTAL CHARGES	104,910,129.36	3,850,570.00

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,137,195.04	ADJUSTMENTS	0.00
COVERED CHARGES	2,087,320.04	CONTRACTUAL ALLOW	976,109.68
NON-COVERD CHARGES	49,875.00	TOTAL MEDICAID LIAB	1,111,210.36
		LESS: COB	1,111,210.36
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 77

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	207		0	171,189.00		47,576.00
ROUTINE NURSERY	144		0	125,557.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	351		0	296,746.00		47,576.00
SPECIAL CARE SERVICES						
CCU	12		0	23,556.00		0.00
ICU	33		0	64,779.00		0.00
NICU	7		0	10,612.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	52		0	98,947.00		0.00
TOTAL ACCOMODATIONS	403		0	395,693.00		47,576.00

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	301,098.04	0.00	OTHER LAB	8,942.00	0.00
MED/SURG SUPPLY	120,267.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	184,540.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,187.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	39,704.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,049.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,950.00	0.00	MRI SERVICES	2,900.00	0.00
IV THERAPY	10,049.00	0.00	PROFESSIONAL FEES	0.00	799.00
OPERATING ROOM	154,305.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	117,472.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	154,509.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	107,257.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,557.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	106,698.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,704.00	0.00	INJECTABLE DRUGS	125,509.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	294.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	868.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	516.00	0.00	TRAUMA RESPONSE	0.00	1,500.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	155,652.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	17,353.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,398.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	2,831.00	0.00			
CARDIOLOGY	12,168.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,710.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,140.00	0.00			
			TOTAL ANCILLARY	1,691,627.04	2,299.00
			TOTAL ACCOMODATIONS	395,693.00	47,576.00
			TOTAL CHARGES	2,087,320.04	49,875.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:28:09
Page: 5

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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	46,196,507.99	ADJUSTMENTS	1,115,576.85
COVERED CHARGES	40,510,627.74	CONTRACTUAL ALLOW	33,184,777.11
NON-COVERD CHARGES	5,685,880.25	TOTAL MEDICAID LIAB	7,325,850.63
		LESS: COB	10,726.25
		LESS: COPAYMENT	17,458.63
		REIMBURSEMENT	7,297,665.75
		ALL OTHER	6,290,504.73
		FEE SCHEDULE-LAB	569,421.60
		INJECTABLE DRUGS	437,739.42

TOTAL NUMBER OF CLAIMS 14,381

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,902,205.41	43,569.00	OTHER LAB	436,307.00	276.00
MED/SURG SUPPLY	1,253,184.00	182,009.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	391.00	EDUCATION & TRAINING	0.00	45.00
RADIOLOGY-DIAGNOSTIC	1,500,296.00	32,947.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,458,002.00	409,735.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	89,146.00	33,948.02	FEE SCHEDULE LAB	6,655,473.37	1,650,511.90
EKG/ECG	467,534.00	22,955.00	MRI SERVICES	1,330,156.00	142,782.00
IV THERAPY	1,529,552.00	98,305.00	PROFESSIONAL FEES	0.00	1,128.00
OPERATING ROOM	2,651,653.05	540,739.95	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	84,871.00	4,999.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	397,007.00	75,891.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	802,679.00	15,263.00	AMBULANCE	0.00	0.00
GI SERVICES	20,970.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,365,439.00	74,639.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,082,766.00	18,187.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,857,724.00	934,453.61
RADIOLOGY THERAPEUTIC	2,417,300.00	154,456.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,460.00	3,808.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,308.00	1,438.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	10,416.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	7,568.00	TRAUMA RESPONSE	0.00	16,000.00
PSYCHIATRIC SERVICES	28,795.00	0.00	IMPL DEV CHARGE PATIENTS	8,849.00	549,778.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	114.00	0.00
OTHER IMAGING SERVICE	1,499,543.50	67,077.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	133,204.00	96,949.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	767,045.00	198,308.00			
AUDIOLOGY	3,325.00	0.00			
CARDIOLOGY	1,187,614.00	182,460.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	643,282.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	924,823.41	114,847.25			
			TOTAL ANCILLARY	40,510,627.74	5,685,880.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	40,510,627.74	5,685,880.25

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:28:09
Page: 7

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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	9815029000030	05/08/14 - 05/08/14	02/02/15	114.00	0.00	0.00	0.00	0.00
TOTAL				114.00	0.00	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	950,263.01	ADJUSTMENTS	0.00
COVERED CHARGES	769,102.01	CONTRACTUAL ALLOW	415,455.94
NON-COVERD CHARGES	181,161.00	TOTAL MEDICAID LIAB	353,646.07
		LESS: COB	353,442.07
		LESS: COPAYMENT	204.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 306

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39,423.01	0.00	OTHER LAB	10,090.00	0.00
MED/SURG SUPPLY	15,571.00	159.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,810.00	491.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	46,125.00	54,682.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,713.00	260.00	FEE SCHEDULE LAB	147,992.00	28,106.00
EKG/ECG	9,625.00	0.00	MRI SERVICES	18,885.00	4,339.00
IV THERAPY	21,526.00	0.00	PROFESSIONAL FEES	0.00	611.00
OPERATING ROOM	55,250.00	19,523.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,423.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,764.00	526.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	28,452.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	157,675.00	992.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	33,459.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	43,361.00	41,184.00
RADIOLOGY THERAPEUTIC	1,823.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,148.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,376.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	69,849.00	11,086.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,232.00	1,504.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	8,053.00	2,993.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,042.00	14,364.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,809.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,626.00	341.00			
			TOTAL ANCILLARY	769,102.01	181,161.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	769,102.01	181,161.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,799,613.00	ADJUSTMENTS	908.98
COVERED CHARGES	1,715,483.00	CONTRACTUAL ALLOW	1,647,068.40
NON-COVERD CHARGES	84,130.00	TOTAL MEDICAID LIAB	68,414.60
		LESS: COB	43.78
		LESS: COPAYMENT	2,037.00
		REIMBURSEMENT	66,333.82
		TOTAL NUMBER OF CLAIMS	1,223

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	67,571.00	209.00	OTHER LAB	8,902.00	0.00
MED/SURG SUPPLY	20,260.00	1,568.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	152,062.00	430.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,328.00	9,305.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	293,992.00	53,772.00
EKG/ECG	22,825.00	0.00	MRI SERVICES	2,554.00	0.00
IV THERAPY	63,567.00	334.00	PROFESSIONAL FEES	0.00	47.00
OPERATING ROOM	0.00	8,307.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,094.00	263.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,211.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	962,805.00	3,305.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,902.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	50,978.00	2,055.00
RADIOLOGY THERAPEUTIC	20,804.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	258.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	18,363.00	2,436.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,270.00	91.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	995.00	1,750.00			
			TOTAL ANCILLARY	1,715,483.00	84,130.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,715,483.00	84,130.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	120,285.00	ADJUSTMENTS	0.00
COVERED CHARGES	103,416.00	CONTRACTUAL ALLOW	64,677.53
NON-COVERD CHARGES	16,869.00	TOTAL MEDICAID LIAB	38,738.47
		LESS: COB	38,696.47
		LESS: COPAYMENT	42.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	36

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,914.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,376.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,025.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	8,380.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,635.00	1,982.00
EKG/ECG	1,100.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,515.00	992.00	PROFESSIONAL FEES	0.00	47.00
OPERATING ROOM	0.00	5,187.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	703.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,251.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	34,550.00	137.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,132.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,187.00	144.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,288.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	740.00	0.00			
			TOTAL ANCILLARY	103,416.00	16,869.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	103,416.00	16,869.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,458,485.56	ADJUSTMENTS	220,572.21
COVERED CHARGES	6,574,479.66	CONTRACTUAL ALLOW	5,561,901.23
NON-COVERD CHARGES	884,005.90	TOTAL MEDICAID LIAB	1,012,578.43
		LESS: COB	0.00
		LESS: COPAYMENT	1,458.00
		REIMBURSEMENT	1,011,120.43
		TOTAL NUMBER OF CLAIMS	183

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	274,835.06	17,891.00	OTHER LAB	3,401.00	0.00
MED/SURG SUPPLY	1,399,379.00	47,022.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	64,667.00	10,789.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	39,431.00	10,631.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	753.00	FEE SCHEDULE LAB	163,338.60	51,607.90
EKG/ECG	29,150.00	5,775.00	MRI SERVICES	20,098.00	53.00
IV THERAPY	235,012.00	13,952.00	PROFESSIONAL FEES	0.00	47.00
OPERATING ROOM	1,130,184.00	236,732.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,687.00	1,180.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	297,726.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	26,957.00	1,984.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	280,455.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,665,263.00	140,481.00
RADIOLOGY THERAPEUTIC	614,751.00	25,479.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,472.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	172.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	12,656.00	141,257.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,032.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,928.00	4,512.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	29,602.00	11,964.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	235,049.00	143,973.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	26,878.00	14,279.00			
			TOTAL ANCILLARY	6,574,479.66	884,005.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,574,479.66	884,005.90

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	128,338.00	ADJUSTMENTS	0.00
COVERED CHARGES	106,840.00	CONTRACTUAL ALLOW	65,376.15
NON-COVERD CHARGES	21,498.00	TOTAL MEDICAID LIAB	41,463.85
		LESS: COB	41,448.85
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

Report : CLM-0814-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 10/01/13 THROUGH 09/30/14 ADMISSION DATES 00/00/00 THROUGH 00/00/00
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PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,969.00	7,299.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	32,403.00	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	949.00	35.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,488.00	496.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,661.00	13,068.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,682.00	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	8,684.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	31,004.00	600.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	106,840.00	21,498.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	106,840.00	21,498.00

** END OF 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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,787,678.94	ADJUSTMENTS	1,208,196.36
COVERED CHARGES	29,116,179.01	CONTRACTUAL ALLOW	21,034,872.02
NON-COVERD CHARGES	671,499.93	TOTAL MEDICAID LIAB	8,081,306.99
		LESS: COB	70,643.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,010,663.90

TOTAL NUMBER OF ADMISSIONS 1,308

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,456		9	3,616,670.00		178,268.00
ROUTINE NURSERY	1,084		15	1,203,601.00		14,289.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	4,540		24	4,820,271.00		192,557.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	600		0	1,488,599.00		0.00
NICU	162		0	484,590.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	762		0	1,973,189.00		0.00
TOTAL ACCOMODATIONS	5,302		24	6,793,460.00		192,557.00

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,697,828.54	382.95	OTHER LAB	106,962.00	0.00
MED/SURG SUPPLY	1,303,845.60	20,703.12	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,170,909.96	40,110.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	557,707.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	904,823.00	23,915.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	129,285.08	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	252,541.00	622.00	MRI SERVICES	472,171.00	0.00
IV THERAPY	474,957.00	30,041.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,553,194.00	52,434.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,181,882.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,585,672.00	7,561.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	91,106.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	651.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	741,035.00	382.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	247,229.00	2,209.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	113,897.00	0.00	INJECTABLE DRUGS	637,038.45	0.00
RADIOLOGY THERAPEUTIC	347,408.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	37,892.02	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	53,564.09	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	175,104.00	1,558.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	14,700.00	3,923.00	TRAUMA RESPONSE	0.00	21,271.00
PSYCHIATRIC SERVICES	154,273.00	217,089.00	IMPL DEV CHARGE PATIENTS	619,909.27	1,987.86
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	34,532.00
OTHER IMAGING SERVICE	132,323.00	10,924.00			
BLOOD	200,513.00	0.00			
BLOOD STORAGE & PRO.	110,512.00	7,144.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	102,181.00	556.00			
AUDIOLOGY	47,242.00	0.00			
CARDIOLOGY	1,031,809.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	45,792.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	26,762.00	1,598.00			
			TOTAL ANCILLARY	22,322,719.01	478,942.93
			TOTAL ACCOMODATIONS	6,793,460.00	192,557.00
			TOTAL CHARGES	29,116,179.01	671,499.93

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:29:30
 Page: 3

HAMILTON MEDICAL CENTER
 1200 MEMORIAL DR
 DALTON,GA 30720-2529

PROVIDER NUMBER
 000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013338040512	11/03/13 - 11/15/13	12/09/13	0.00	2,390.00	0.00	0.00	0.00
614	2013350000730	11/28/13 - 11/29/13	12/23/13	0.00	4,811.00	0.00	0.00	0.00
614	2014086080222	03/15/14 - 03/21/14	03/31/14	0.00	4,811.00	0.00	0.00	0.00
614	2214121011299	01/02/14 - 03/24/14	05/05/14	0.00	5,783.00	0.00	0.00	0.00
614	9714134954001	10/22/13 - 10/25/13	05/19/14	0.00	1,646.00	0.00	0.00	0.00
614	2014210061620	10/31/13 - 11/02/13	08/04/14	0.00	2,390.00	0.00	0.00	0.00
614	5214224001304	11/04/13 - 11/20/13	08/18/14	0.00	4,780.00	0.00	0.00	0.00
614	2014258031797	07/21/14 - 07/29/14	09/22/14	0.00	5,292.00	0.00	0.00	0.00
614	2014283062387	08/15/14 - 08/18/14	10/20/14	0.00	2,629.00	0.00	0.00	0.00
TOTAL				0.00	34,532.00	0.00	0.00	0.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:29:36
 Page: 4

HAMILTON MEDICAL CENTER
 1200 MEMORIAL DR
 DALTON,GA 30720-2529

PROVIDER NUMBER 000000899A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	132,428.16	ADJUSTMENTS	0.00
COVERED CHARGES	131,515.16	CONTRACTUAL ALLOW	63,187.29
NON-COVERD CHARGES	913.00	TOTAL MEDICAID LIAB	68,327.87
		LESS: COB	68,327.87
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 13

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	23		0	24,036.00		913.00
ROUTINE NURSERY	5		0	3,300.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	28		0	27,336.00		913.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	28		0	27,336.00		913.00

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,945.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,472.21	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	16,705.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	536.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	358.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	583.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,621.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	51,135.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,829.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	693.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,040.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,115.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	476.00	0.00	INJECTABLE DRUGS	385.70	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	76.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	228.00	0.00			
CARDIOLOGY	1,981.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	104,179.16	0.00
			TOTAL ACCOMODATIONS	27,336.00	913.00
			TOTAL CHARGES	131,515.16	913.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:29:39
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HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,931,464.23	ADJUSTMENTS	336,884.16
COVERED CHARGES	22,069,285.16	CONTRACTUAL ALLOW	18,189,070.39
NON-COVERD CHARGES	1,862,179.07	TOTAL MEDICAID LIAB	3,880,214.77
		LESS: COB	4,838.70
		LESS: COPAYMENT	7,933.38
		REIMBURSEMENT	3,867,442.69
		ALL OTHER	3,321,137.76
		FEE SCHEDULE-LAB	322,563.14
		INJECTABLE DRUGS	223,741.79

TOTAL NUMBER OF CLAIMS 9,063

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	665,163.32	6,872.90	OTHER LAB	344,516.00	457.00
MED/SURG SUPPLY	665,327.48	12,620.20	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	2,091.00	359.00
RADIOLOGY-DIAGNOSTIC	1,263,881.00	7,864.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,706,360.00	123,212.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	40,124.00	18,580.02	FEE SCHEDULE LAB	5,455,845.21	960,851.28
EKG/ECG	428,167.00	13,497.00	MRI SERVICES	1,010,013.00	111,029.00
IV THERAPY	1,445,203.00	242,606.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,239,342.65	144,427.69	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	22,532.00	2,546.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	206,922.00	36,822.00	FREE STANDING CLINIC	0.00	223.00
ANESTHESIA	107,101.00	140.00	AMBULANCE	0.00	0.00
GI SERVICES	2,111.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,052,188.17	15,786.83	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	141,835.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	881,075.85	37,205.45
RADIOLOGY THERAPEUTIC	516,606.00	12,052.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	22,142.00	4,621.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	220.00	2,790.02	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	6,056.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	112,770.00	2,079.00	TRAUMA RESPONSE	0.00	12,888.00
PSYCHIATRIC SERVICES	0.00	3,762.00	IMPL DEV CHARGE PATIENTS	40,583.48	9,404.68
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	10,630.00
OTHER IMAGING SERVICE	901,286.00	26,179.00			
BLOOD	21,007.00	664.00			
BLOOD STORAGE & PRO.	11,172.00	760.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	302,125.00	41.00			
AUDIOLOGY	0.00	114.00			
CARDIOLOGY	639,977.00	33,557.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	399,506.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	422,092.00	1,482.00			
			TOTAL ANCILLARY	22,069,285.16	1,862,179.07
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	22,069,285.16	1,862,179.07

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:29:39
Page: 8

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014219059599	07/30/14 - 07/30/14	08/11/14	0.00	3,210.00	0.00	0.00	0.00
614	2014247089196	08/29/14 - 08/29/14	09/08/14	0.00	3,710.00	0.00	0.00	0.00
614	2014260079436	09/10/14 - 09/10/14	09/22/14	0.00	3,710.00	0.00	0.00	0.00
TOTAL				0.00	10,630.00	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:30:04
Page: 9

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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	494,167.89	ADJUSTMENTS	0.00
COVERED CHARGES	424,197.89	CONTRACTUAL ALLOW	176,403.63
NON-COVERD CHARGES	69,970.00	TOTAL MEDICAID LIAB	247,794.26
		LESS: COB	247,617.26
		LESS: COPAYMENT	177.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 187

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,874.59	0.00	OTHER LAB	8,445.00	0.00
MED/SURG SUPPLY	13,947.34	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,303.00	1,430.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,724.00	19,188.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,882.00	110.00	FEE SCHEDULE LAB	122,075.96	21,553.00
EKG/ECG	5,989.00	0.00	MRI SERVICES	17,862.00	5,503.00
IV THERAPY	24,102.00	2,990.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	28,495.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,706.00	314.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,635.00	303.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,578.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	66,080.00	107.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,788.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,589.35	0.00
RADIOLOGY THERAPEUTIC	23,674.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	154.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,035.00	0.00	TRAUMA RESPONSE	0.00	1,644.00
PSYCHIATRIC SERVICES	0.00	330.00	IMPL DEV CHARGE PATIENTS	2,432.65	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,968.00
OTHER IMAGING SERVICE	22,452.00	2,107.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,958.00	139.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,179.00	11,536.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,237.00	748.00			
			TOTAL ANCILLARY	424,197.89	69,970.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	424,197.89	69,970.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:30:04
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014209029985	06/26/14 - 06/26/14	08/04/14	0.00	1,968.00	0.00	6,902.30	0.00
TOTAL				0.00	1,968.00	0.00	6,902.30	0.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:30:07
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HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,243,687.85	ADJUSTMENTS	794.10
COVERED CHARGES	1,198,133.37	CONTRACTUAL ALLOW	1,145,168.52
NON-COVERD CHARGES	45,554.48	TOTAL MEDICAID LIAB	52,964.85
		LESS: COB	29.89
		LESS: COPAYMENT	2,205.00
		REIMBURSEMENT	50,729.96
		TOTAL NUMBER OF CLAIMS	947

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,309.56	245.45	OTHER LAB	8,235.00	0.00
MED/SURG SUPPLY	11,348.71	577.03	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	116,750.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	35,647.00	4,630.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	311,767.00	28,348.00
EKG/ECG	28,234.00	0.00	MRI SERVICES	13,884.00	0.00
IV THERAPY	86,668.00	7,372.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,893.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	314.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,159.00	944.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	506,083.00	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	1,633.10	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	404.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	1,650.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	23,767.00	1,063.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,981.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,436.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,620.00	0.00			
			TOTAL ANCILLARY	1,198,133.37	45,554.48
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,198,133.37	45,554.48

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,451.45	ADJUSTMENTS	0.00
COVERED CHARGES	16,751.45	CONTRACTUAL ALLOW	7,226.68
NON-COVERD CHARGES	700.00	TOTAL MEDICAID LIAB	9,524.77
		LESS: COB	9,512.77
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	11

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	369.40	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	84.05	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,125.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,608.00	91.00
EKG/ECG	327.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	796.00	246.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,061.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	363.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,381.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	16,751.45	700.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,751.45	700.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,875,072.47	ADJUSTMENTS	93,397.03
COVERED CHARGES	3,680,663.43	CONTRACTUAL ALLOW	3,118,084.55
NON-COVERD CHARGES	194,409.04	TOTAL MEDICAID LIAB	562,578.88
		LESS: COB	10,932.85
		LESS: COPAYMENT	1,050.00
		REIMBURSEMENT	550,596.03
		TOTAL NUMBER OF CLAIMS	102

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,084.82	177.00	OTHER LAB	1,139.00	0.00
MED/SURG SUPPLY	83,424.84	7,500.16	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,541.00	755.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	106,882.00	1,558.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,320.05	FEE SCHEDULE LAB	113,694.45	27,295.50
EKG/ECG	14,367.00	3,825.00	MRI SERVICES	25,919.00	4,091.00
IV THERAPY	111,112.00	12,570.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	488,728.00	10,419.00	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	504.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,112.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,190.00	2,139.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,003.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,274,855.30	39,319.70
RADIOLOGY THERAPEUTIC	767,516.00	1,026.00	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	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,784.00	0.01	TRAUMA RESPONSE	0.00	1,644.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	307,319.02	17,739.62
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,968.00
OTHER IMAGING SERVICE	2,116.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	21,611.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	234,653.00	60,558.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,271.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,777.00	0.00			
			TOTAL ANCILLARY	3,680,663.43	194,409.04
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,680,663.43	194,409.04

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014003056097	10/17/13 - 10/17/13	01/13/14	0.00	1,968.00	0.00	0.00	0.00
TOTAL				0.00	1,968.00	0.00	0.00	0.00

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,623.27	ADJUSTMENTS	0.00
COVERED CHARGES	23,623.27	CONTRACTUAL ALLOW	8,987.45
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	14,635.82
		LESS: COB	14,632.82
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	350.30	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	802.97	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	475.00	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	228.00	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	21,767.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	23,623.27	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	23,623.27	0.00

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	215,546,671.68	ADJUSTMENTS	30,069,160.30
COVERED CHARGES	208,566,244.85	CONTRACTUAL ALLOW	130,094,577.32
NON-COVERD CHARGES	6,980,426.83	TOTAL MEDICAID LIAB	78,471,667.53
		LESS: COB	196,562.02
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	78,275,105.51

TOTAL NUMBER OF ADMISSIONS 2,907

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	13,539		17	13,320,144.00		4,888,499.50
ROUTINE NURSERY	1,044		0	2,116,609.50		27,439.50
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	14,583		17	15,436,753.50		4,915,939.00
SPECIAL CARE SERVICES						
CCU	1,531		0	5,644,617.50		0.00
ICU	0		0	0.00		0.00
NICU	1,726		0	8,598,202.00		0.00
PED ICU	3,723		0	13,876,526.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	6,980		0	28,119,345.50		0.00
TOTAL ACCOMODATIONS	21,563		17	43,556,099.00		4,915,939.00

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	44,492,218.62	643,265.53	OTHER LAB	519,185.50	0.00
MED/SURG SUPPLY	12,683,047.71	88,768.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	25,142,922.06	529,553.00	EDUCATION & TRAINING	513.50	0.00
RADIOLOGY-DIAGNOSTIC	2,931,039.50	0.00	OTHER THERAPEUTIC SVC	38,100.50	106,144.50
CT SCAN	1,061,317.50	2,492.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	874,150.00	4,980.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	178,380.00	0.00	MRI SERVICES	1,027,916.00	0.00
IV THERAPY	85,749.00	12,167.00	PROFESSIONAL FEES	0.00	11,702.00
OPERATING ROOM	19,115,143.00	727.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	16,892,128.50	76,318.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,098,541.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	12,549.00	1,378.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,024,216.50	52,420.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,177,021.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,157,295.95	423.30	INJECTABLE DRUGS	462,942.50	0.00
RADIOLOGY THERAPEUTIC	175,763.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	425,125.00	1,992.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	476,014.00	2,405.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	78,122.00	65,168.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	344.00	43,226.50	TRAUMA RESPONSE	0.00	62,330.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	10,677,452.51	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	442,474.50	143,974.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,246,946.50	89,798.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	236,483.50	4,669.50			
AUDIOLOGY	38,596.50	0.00			
CARDIOLOGY	4,220,045.00	2,728.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,283,437.00	0.00			
ORGAN ACQUISITION	2,576,618.00	117,246.50			
TREATMENT/OBSERV. RM	158,347.00	609.00			
			TOTAL ANCILLARY	165,010,145.85	2,064,487.83
			TOTAL ACCOMODATIONS	43,556,099.00	4,915,939.00
			TOTAL CHARGES	208,566,244.85	6,980,426.83

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 00:50:19
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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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,047,596.60	ADJUSTMENTS	0.00
COVERED CHARGES	6,897,892.10	CONTRACTUAL ALLOW	444,390.65
NON-COVERD CHARGES	149,704.50	TOTAL MEDICAID LIAB	6,453,501.45
		LESS: COB	6,453,501.45
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 98

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	355		0	351,450.00		101,686.50
ROUTINE NURSERY	44		0	96,420.00		426.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	399		0	447,870.00		102,112.50
SPECIAL CARE SERVICES						
CCU	35		0	128,817.50		0.00
ICU	0		0	0.00		0.00
NICU	108		0	535,517.00		0.00
PED ICU	49		0	189,485.50		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	192		0	853,820.00		0.00
TOTAL ACCOMODATIONS	591		0	1,301,690.00		102,112.50

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,117,259.75	0.00	OTHER LAB	30,920.50	0.00
MED/SURG SUPPLY	357,509.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	736,957.10	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	81,630.00	0.00	OTHER THERAPEUTIC SVC	3,901.00	2,308.00
CT SCAN	24,356.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	27,463.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,292.00	0.00	MRI SERVICES	25,533.50	0.00
IV THERAPY	1,469.50	0.00	PROFESSIONAL FEES	0.00	35,402.00
OPERATING ROOM	724,861.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	385,750.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	289,420.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	689.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	99,959.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	48,041.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	31,844.00	0.00	INJECTABLE DRUGS	990.00	0.00
RADIOLOGY THERAPEUTIC	16,417.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	12,395.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	10,209.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	404.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,092,086.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,713.50	9,477.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	68,354.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	14,673.00	0.00			
AUDIOLOGY	2,286.00	0.00			
CARDIOLOGY	139,526.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	234,513.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,180.50	0.00			
			TOTAL ANCILLARY	5,596,202.10	47,592.00
			TOTAL ACCOMODATIONS	1,301,690.00	102,112.50
			TOTAL CHARGES	6,897,892.10	149,704.50

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	62,148,261.27	ADJUSTMENTS	5,712,922.26
COVERED CHARGES	56,724,548.43	CONTRACTUAL ALLOW	42,005,623.23
NON-COVERD CHARGES	5,423,712.84	TOTAL MEDICAID LIAB	14,718,925.20
		LESS: COB	12,619.16
		LESS: COPAYMENT	252.00
		REIMBURSEMENT	14,706,054.04
		ALL OTHER	11,885,494.22
		FEE SCHEDULE-LAB	829,704.01
		INJECTABLE DRUGS	1,990,855.81
		TOTAL NUMBER OF CLAIMS	19,688

Report : CLM-0804-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,191,441.50	5,729.00	OTHER LAB	318,470.50	5,804.50
MED/SURG SUPPLY	3,350,215.00	4,128.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	943.00	EDUCATION & TRAINING	2,054.00	0.00
RADIOLOGY-DIAGNOSTIC	1,303,632.50	35,625.00	OTHER THERAPEUTIC SVC	547.00	1,315.00
CT SCAN	1,109,610.00	56,076.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	108,525.50	14,746.00	FEE SCHEDULE LAB	10,493,233.80	2,930,946.74
EKG/ECG	78,100.00	10,310.00	MRI SERVICES	2,545,623.00	181,016.00
IV THERAPY	1,067,788.00	63,492.50	PROFESSIONAL FEES	0.00	11,651.50
OPERATING ROOM	6,722,685.13	516,614.35	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	813,638.00	37,464.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,949,152.50	3,181.00	AMBULANCE	0.00	0.00
GI SERVICES	368,252.00	19,949.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,353,289.50	91,489.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,570,884.00	0.00	DRUG-SPECIFIC/HOME IV	545.00	1,638.50
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,780,096.50	663,790.25
RADIOLOGY THERAPEUTIC	302,697.50	4,753.50	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	34,595.00	3,251.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	328,303.50	10,567.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,166.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,434,711.50	141,812.00	TRAUMA RESPONSE	0.00	39,930.50
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	542,640.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	603.50
OTHER IMAGING SERVICE	773,654.50	35,630.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	900,979.50	8,584.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	374,613.00	18,223.50			
AUDIOLOGY	156,307.00	2,987.00			
CARDIOLOGY	2,503,153.50	357,331.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,322,164.00	7,004.00			
ORGAN ACQUISITION	0.00	114,951.50			
TREATMENT/OBSERV. RM	922,946.00	21,007.50			
			TOTAL ANCILLARY	56,724,548.43	5,423,712.84
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	56,724,548.43	5,423,712.84

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5914358000041	11/24/14 - 11/24/14	12/29/14	0.00	603.50	0.00	0.00	0.00
TOTAL				0.00	603.50	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,841,313.30	ADJUSTMENTS	0.00
COVERED CHARGES	1,496,915.55	CONTRACTUAL ALLOW	36,459.11
NON-COVERD CHARGES	344,397.75	TOTAL MEDICAID LIAB	1,460,456.44
		LESS: COB	1,460,438.44
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 226

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	91,047.25	61.25	OTHER LAB	4,715.00	806.00
MED/SURG SUPPLY	127,369.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,425.50	420.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	40,081.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	902.00	FEE SCHEDULE LAB	134,196.05	32,825.50
EKG/ECG	992.00	496.00	MRI SERVICES	131,804.50	12,559.50
IV THERAPY	6,343.50	2,536.50	PROFESSIONAL FEES	0.00	10,421.50
OPERATING ROOM	275,721.00	87,405.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,696.50	555.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	221,857.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	32,380.50	1,303.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	64,145.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	177,372.25	96,212.00
RADIOLOGY THERAPEUTIC	14,732.00	583.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	879.50	1,639.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,941.50	2,054.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	22,292.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,129.50	18,955.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	30,328.50	17,838.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,708.50	378.00			
AUDIOLOGY	653.00	0.00			
CARDIOLOGY	45,763.50	43,441.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,870.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,471.00	13,005.00			
			TOTAL ANCILLARY	1,496,915.55	344,397.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,496,915.55	344,397.75

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,455,610.38	ADJUSTMENTS	3,188.58
COVERED CHARGES	1,380,989.81	CONTRACTUAL ALLOW	1,304,575.78
NON-COVERD CHARGES	74,620.57	TOTAL MEDICAID LIAB	76,414.03
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	76,402.03
		TOTAL NUMBER OF CLAIMS	1,366

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39,892.50	0.00	OTHER LAB	10,847.50	0.00
MED/SURG SUPPLY	26,215.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	65.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	86,497.50	225.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	42,412.50	1,543.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	202,302.06	64,527.32
EKG/ECG	5,208.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	439.50	0.00	PROFESSIONAL FEES	0.00	3,194.00
OPERATING ROOM	15,904.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,105.00	70.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	483.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	900,452.00	3,486.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	752.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	21,221.50	333.75
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	879.50	389.50	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	282.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	881.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,966.00	515.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,941.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,308.00	270.00			
			TOTAL ANCILLARY	1,380,989.81	74,620.57
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,380,989.81	74,620.57

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	37,473.75	ADJUSTMENTS	0.00
COVERED CHARGES	33,369.00	CONTRACTUAL ALLOW	4,533.91
NON-COVERD CHARGES	4,104.75	TOTAL MEDICAID LIAB	28,835.09
		LESS: COB	28,835.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	6

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,670.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,223.00	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	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	246.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	2,599.50
OPERATING ROOM	7,163.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,442.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	241.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,886.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	931.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	128.75	200.25
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	359.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	630.00	1,305.00			
			TOTAL ANCILLARY	33,369.00	4,104.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	33,369.00	4,104.75

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,927,826.93	ADJUSTMENTS	1,035,989.69
COVERED CHARGES	11,830,568.23	CONTRACTUAL ALLOW	10,051,295.30
NON-COVERD CHARGES	1,097,258.70	TOTAL MEDICAID LIAB	1,779,272.93
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,779,272.93

TOTAL NUMBER OF CLAIMS 187

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	313,364.75	485.75	OTHER LAB	4,574.50	809.00
MED/SURG SUPPLY	1,931,930.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	289,618.50	66,671.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,543.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	4,277.50	FEE SCHEDULE LAB	250,407.00	232,771.45
EKG/ECG	2,146.50	2,976.00	MRI SERVICES	17,852.50	2,894.00
IV THERAPY	33,185.00	23,613.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,027,389.00	168,651.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,555.00	114.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	939,450.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	68,486.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,853.50	502.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	196,229.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	596,814.25	15,711.50
RADIOLOGY THERAPEUTIC	6,413.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	664.00	1,645.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,269.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,983.00	846.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,347,565.33	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,141.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,063.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,279.50	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,689,064.00	536,229.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	10,548.00	3,816.50			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	68,446.50	33,975.00			
			TOTAL ANCILLARY	11,830,568.23	1,097,258.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,830,568.23	1,097,258.70

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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SUMMARY TYPE VIII

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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	813,225.78	ADJUSTMENTS	0.00
COVERED CHARGES	797,284.28	CONTRACTUAL ALLOW	57,421.14
NON-COVERD CHARGES	15,941.50	TOTAL MEDICAID LIAB	739,863.14
		LESS: COB	739,863.14
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	10

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,389.75	0.00	OTHER LAB	1,421.50	0.00
MED/SURG SUPPLY	42,616.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,189.50	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	15,598.50	6,664.50
EKG/ECG	0.00	248.00	MRI SERVICES	0.00	0.00
IV THERAPY	149.00	555.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	75,078.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	40,594.50	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	6,260.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	58,370.50	1,034.50
RADIOLOGY THERAPEUTIC	920.50	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	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	488,783.03	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	515.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	37,398.00	3,344.50			
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	4,095.00			
			TOTAL ANCILLARY	797,284.28	15,941.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	797,284.28	15,941.50

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	846,835.50	ADJUSTMENTS	8,823.58
COVERED CHARGES	844,451.50	CONTRACTUAL ALLOW	539,730.84
NON-COVERD CHARGES	2,384.00	TOTAL MEDICAID LIAB	304,720.66
		LESS: COB	4,006.99
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	300,713.67

TOTAL NUMBER OF ADMISSIONS 44

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	80		0	79,040.00		2,384.00
ROUTINE NURSERY	0		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	79,040.00		2,384.00
SPECIAL CARE SERVICES						
CCU	41		0	64,616.00		0.00
ICU	16		0	38,480.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	57		0	103,096.00		0.00
TOTAL ACCOMODATIONS	137		0	182,136.00		2,384.00

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	120,337.40	0.00	OTHER LAB	4,847.00	0.00
MED/SURG SUPPLY	35,036.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	173,801.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,036.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	87,607.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,764.36	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,640.00	0.00	MRI SERVICES	7,746.00	0.00
IV THERAPY	23,661.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,522.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	53,088.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	63,080.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	424.00	0.00	INJECTABLE DRUGS	11,956.74	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	901.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,086.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,117.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,836.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	17,321.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,508.00	0.00			
			TOTAL ANCILLARY	662,315.50	0.00
			TOTAL ACCOMODATIONS	182,136.00	2,384.00
			TOTAL CHARGES	844,451.50	2,384.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,357,171.72	ADJUSTMENTS	138,332.66
COVERED CHARGES	5,098,970.43	CONTRACTUAL ALLOW	3,914,980.01
NON-COVERD CHARGES	258,201.29	TOTAL MEDICAID LIAB	1,183,990.42
		LESS: COB	378.71
		LESS: COPAYMENT	3,570.00
		REIMBURSEMENT	1,180,041.71
		ALL OTHER	1,110,623.07
		FEE SCHEDULE-LAB	62,847.58
		INJECTABLE DRUGS	6,571.06
		TOTAL NUMBER OF CLAIMS	2,382

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	184,481.36	284.84	OTHER LAB	32,776.00	0.00
MED/SURG SUPPLY	135,719.19	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	290,105.00	497.00	OTHER THERAPEUTIC SVC	0.00	218.00
CT SCAN	861,626.00	24,153.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	147,096.00	16,094.00	FEE SCHEDULE LAB	880,544.30	151,065.50
EKG/ECG	63,658.00	2,892.00	MRI SERVICES	251,111.00	0.00
IV THERAPY	250,347.00	20,509.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	199,074.00	17,871.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	37,229.00	2,124.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	94,020.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	48,299.00	3,161.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,176,438.00	1,614.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	49,810.62	10,797.95
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	166.00	1,729.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	43,688.00	0.00	IMPL DEV CHARGE PATIENTS	11,246.96	0.00
LITHOTRIPSY	105,750.00	1,700.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	88,274.00	3,491.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	13,090.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	45,913.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	38,915.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	49,593.00	0.00			
			TOTAL ANCILLARY	5,098,970.43	258,201.29
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,098,970.43	258,201.29

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,007.54	ADJUSTMENTS	0.00
COVERED CHARGES	7,867.00	CONTRACTUAL ALLOW	4,020.91
NON-COVERD CHARGES	140.54	TOTAL MEDICAID LIAB	3,846.09
		LESS: COB	3,843.09
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11.00	140.54	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	6,722.00	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	222.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	879.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	33.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,867.00	140.54
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,867.00	140.54

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	285,080.86	ADJUSTMENTS	435.00
COVERED CHARGES	278,862.86	CONTRACTUAL ALLOW	265,012.86
NON-COVERD CHARGES	6,218.00	TOTAL MEDICAID LIAB	13,850.00
		LESS: COB	0.00
		LESS: COPAYMENT	555.00
		REIMBURSEMENT	13,295.00
		TOTAL NUMBER OF CLAIMS	277

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,515.14	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,435.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,160.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	27,800.00	1,823.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	56,778.00	3,753.00
EKG/ECG	3,615.00	241.00	MRI SERVICES	0.00	0.00
IV THERAPY	16,546.00	296.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,073.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	141,264.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,676.72	105.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	278,862.86	6,218.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	278,862.86	6,218.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	630.00	ADJUSTMENTS	0.00
COVERED CHARGES	630.00	CONTRACTUAL ALLOW	432.60
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	197.40
		LESS: COB	191.40
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 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	630.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPTY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	630.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	630.00	0.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	173,278.20	ADJUSTMENTS	4,651.20
COVERED CHARGES	170,550.20	CONTRACTUAL ALLOW	146,976.00
NON-COVERD CHARGES	2,728.00	TOTAL MEDICAID LIAB	23,574.20
		LESS: COB	0.00
		LESS: COPAYMENT	69.00
		REIMBURSEMENT	23,505.20

TOTAL NUMBER OF CLAIMS 5

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,173.70	0.00	OTHER LAB	1,118.00	0.00
MED/SURG SUPPLY	14,600.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,001.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,329.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,890.00	2,424.00
EKG/ECG	964.00	241.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,736.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	23,703.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,334.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,048.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,258.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	44,793.00	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	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,837.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	662.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	13,853.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,250.00	0.00			
			TOTAL ANCILLARY	170,550.20	2,728.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	170,550.20	2,728.00

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF 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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,545,770.05	ADJUSTMENTS	1,053,672.58
COVERED CHARGES	26,229,677.81	CONTRACTUAL ALLOW	16,743,137.73
NON-COVERD CHARGES	1,316,092.24	TOTAL MEDICAID LIAB	9,486,540.08
		LESS: COB	157,858.66
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,328,681.42

TOTAL NUMBER OF ADMISSIONS 1,437

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5,355		7	3,395,646.00		1,181,292.00
ROUTINE NURSERY	509		8	286,681.00		4,400.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5,864		15	3,682,327.00		1,185,692.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,008		0	1,537,446.00		0.00
NICU	17		1	32,232.00		1,896.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,025		1	1,569,678.00		1,896.00
TOTAL ACCOMODATIONS	6,889		16	5,252,005.00		1,187,588.00

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,447,757.46	33,106.01	OTHER LAB	174,751.00	0.00
MED/SURG SUPPLY	340,312.05	5,582.96	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,281,677.84	18,700.48	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	662,544.00	1,410.00	OTHER THERAPEUTIC SVC	0.00	166.00
CT SCAN	2,218,200.39	16,406.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	308,883.18	1,365.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	474,714.00	596.00	MRI SERVICES	499,337.00	0.00
IV THERAPY	11,738.00	422.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,373,562.35	2,150.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	791,590.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	976,806.90	2,281.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	169,992.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,196,782.25	1,195.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	182,502.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	73,018.07	0.00	INJECTABLE DRUGS	367.78	0.00
RADIOLOGY THERAPEUTIC	6,767.00	1,996.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	268.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	83,238.09	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	155,280.00	4,529.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,134.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	371,036.68	719.34
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	15,487.00
OTHER IMAGING SERVICE	195,265.00	6,881.00			
BLOOD	4,641.00	0.00			
BLOOD STORAGE & PRO.	211,034.89	9,889.99			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	92,221.00	3,797.46			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,404,115.24	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	104,290.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	161,845.64	1,824.00			
			TOTAL ANCILLARY	20,977,672.81	128,504.24
			TOTAL ACCOMODATIONS	5,252,005.00	1,187,588.00
			TOTAL CHARGES	26,229,677.81	1,316,092.24

Report : CLM-0800-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:30:27
Page: 3

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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	9114223000027	05/25/14 - 05/30/14	08/18/14	0.00	3,395.00	0.00	1,425.25	0.00
618	9114227005336	04/05/14 - 04/11/14	09/01/14	0.00	1,907.00	0.00	1,665.40	0.00
615	2315040000335	08/31/14 - 09/09/14	03/02/15	0.00	3,395.00	0.00	1,615.05	0.00
615	2315070000059	12/18/14 - 12/20/14	03/30/15	0.00	3,395.00	0.00	670.48	0.00
615	2315104000011	10/17/14 - 10/24/14	04/27/15	0.00	3,395.00	0.00	1,562.01	0.00
TOTAL				0.00	15,487.00	0.00	6,938.19	0.00

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	179,244.18	ADJUSTMENTS	0.00
COVERED CHARGES	146,224.18	CONTRACTUAL ALLOW	72,759.12
NON-COVERD CHARGES	33,020.00	TOTAL MEDICAID LIAB	73,465.06
		LESS: COB	73,465.06
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 13

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	50		0	31,950.00		33,020.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	50		0	31,950.00		33,020.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	5		0	4,785.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	5		0	4,785.00		0.00
TOTAL ACCOMODATIONS	55		0	36,735.00		33,020.00

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,606.06	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,890.47	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	20,075.98	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	673.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,824.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,447.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	596.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	980.76	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	37,346.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	246.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,019.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	478.91	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	669.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,637.00	0.00			
			TOTAL ANCILLARY	109,489.18	0.00
			TOTAL ACCOMODATIONS	36,735.00	33,020.00
			TOTAL CHARGES	146,224.18	33,020.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:30:37
Page: 6

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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,660,238.81	ADJUSTMENTS	637,747.43
COVERED CHARGES	15,961,082.20	CONTRACTUAL ALLOW	12,623,152.90
NON-COVERD CHARGES	1,699,156.61	TOTAL MEDICAID LIAB	3,337,929.30
		LESS: COB	30,916.60
		LESS: COPAYMENT	9,897.13
		REIMBURSEMENT	3,297,115.57
		ALL OTHER	2,686,010.89
		FEE SCHEDULE-LAB	273,278.32
		INJECTABLE DRUGS	337,826.36

TOTAL NUMBER OF CLAIMS 7,592

Report : CLM-0804-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:30:37
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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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	225,047.88	5,588.29	OTHER LAB	211,025.00	0.00
MED/SURG SUPPLY	160,868.40	13,151.78	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	878.00	EDUCATION & TRAINING	3,000.00	142.00
RADIOLOGY-DIAGNOSTIC	879,376.98	7,665.00	OTHER THERAPEUTIC SVC	0.00	747.00
CT SCAN	2,388,241.20	259,233.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	45,100.00	24,135.09	FEE SCHEDULE LAB	2,997,359.41	658,857.60
EKG/ECG	359,713.00	12,218.00	MRI SERVICES	442,637.00	26,970.00
IV THERAPY	647,638.00	25,010.00	PROFESSIONAL FEES	0.00	59.40
OPERATING ROOM	1,786,041.05	192,930.07	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,311.00	0.00	REHAB THERAPY	0.00	832.00
RESPIRATORY SERVICES	44,925.00	10,217.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	207,175.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,475,877.32	5,905.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	402,376.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	800,753.94	212,368.55
RADIOLOGY THERAPEUTIC	20,394.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	25,614.00	11,476.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,658.00	3,305.21	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,505.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	13,348.07	3,751.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	75,990.77	4,869.81
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	699,659.59	67,394.89			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	32,174.73	5,307.94			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	160,327.00	5,199.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	497,507.47	135,602.98			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	46,702.00	649.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	304,240.39	188.00			
			TOTAL ANCILLARY	15,961,082.20	1,699,156.61
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,961,082.20	1,699,156.61

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	556,902.19	ADJUSTMENTS	0.00
COVERED CHARGES	375,115.80	CONTRACTUAL ALLOW	142,924.01
NON-COVERD CHARGES	181,786.39	TOTAL MEDICAID LIAB	232,191.79
		LESS: COB	231,893.79
		LESS: COPAYMENT	298.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 299

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,748.72	151.00	OTHER LAB	5,677.00	0.00
MED/SURG SUPPLY	4,434.59	79.40	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	254.00	332.00
RADIOLOGY-DIAGNOSTIC	16,396.92	974.00	OTHER THERAPEUTIC SVC	0.00	1,660.00
CT SCAN	21,562.00	39,100.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	91,039.76	18,307.75
EKG/ECG	6,556.00	894.00	MRI SERVICES	5,185.00	0.00
IV THERAPY	20,770.00	1,230.00	PROFESSIONAL FEES	0.00	478.20
OPERATING ROOM	27,052.68	28,933.19	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	483.00	344.00	FREE STANDING CLINIC	300.00	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	78,415.00	525.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,815.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,180.58	53,914.71
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,298.00	1,648.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	265.00	960.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,943.00	62.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	24,487.42	15,559.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	472.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,692.00	1,440.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,391.00	14,608.14			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,466.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,020.13	114.00			
			TOTAL ANCILLARY	375,115.80	181,786.39
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	375,115.80	181,786.39

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:31:11
Page: 10

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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	411,705.09	ADJUSTMENTS	1,621.20
COVERED CHARGES	395,069.76	CONTRACTUAL ALLOW	364,414.64
NON-COVERD CHARGES	16,635.33	TOTAL MEDICAID LIAB	30,655.12
		LESS: COB	0.00
		LESS: COPAYMENT	909.00
		REIMBURSEMENT	29,746.12
		TOTAL NUMBER OF CLAIMS	548

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,982.96	0.00	OTHER LAB	2,949.00	0.00
MED/SURG SUPPLY	394.13	127.06	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	29,202.00	521.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,623.00	2,410.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	63,243.55	10,552.85
EKG/ECG	5,066.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,552.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,604.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	925.00	86.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	239,718.00	402.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	280.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,744.46	1,158.42
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	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	755.66	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,642.00	906.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	472.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	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	395,069.76	16,635.33
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	395,069.76	16,635.33

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:31:14
Page: 12

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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	58,431.36	ADJUSTMENTS	0.00
COVERED CHARGES	49,378.86	CONTRACTUAL ALLOW	36,333.76
NON-COVERD CHARGES	9,052.50	TOTAL MEDICAID LIAB	13,045.10
		LESS: COB	13,009.10
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	34

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	580.46	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	115.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,637.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,410.00	2,410.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	15,577.98	2,208.00
EKG/ECG	298.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	265.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,408.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	347.02	240.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,235.00	4,079.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	620.40	0.00			
			TOTAL ANCILLARY	49,378.86	9,052.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	49,378.86	9,052.50

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	415,192.30	ADJUSTMENTS	28,005.55
COVERED CHARGES	381,947.35	CONTRACTUAL ALLOW	281,019.37
NON-COVERD CHARGES	33,244.95	TOTAL MEDICAID LIAB	100,927.98
		LESS: COB	0.00
		LESS: COPAYMENT	153.00
		REIMBURSEMENT	100,774.98

TOTAL NUMBER OF CLAIMS 18

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,667.06	38.68	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,122.67	8,197.33	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,986.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	7,466.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	607.00	FEE SCHEDULE LAB	22,526.61	3,137.00
EKG/ECG	1,788.00	1,192.00	MRI SERVICES	14,265.00	0.00
IV THERAPY	16,467.00	123.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	61,262.89	4,710.98	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,784.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,186.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,432.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	130,265.00	5,292.01
RADIOLOGY THERAPEUTIC	4,420.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	28.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	28,150.20	2,452.95
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,485.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	67,824.42	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	822.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,493.50	0.00			
			TOTAL ANCILLARY	381,947.35	33,244.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	381,947.35	33,244.95

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:31:26
 Page: 1

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 12/01/13 THROUGH 11/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,743,426.85	ADJUSTMENTS	226,403.78
COVERED CHARGES	1,646,701.17	CONTRACTUAL ALLOW	726,480.50
NON-COVERD CHARGES	96,725.68	TOTAL MEDICAID LIAB	920,220.67
		LESS: COB	1,679.23
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	918,541.44

TOTAL NUMBER OF ADMISSIONS 277

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	506		0	253,000.00		59,800.00
ROUTINE NURSERY	203		0	101,500.00		19,995.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	709		0	354,500.00		79,795.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	709		0	354,500.00		79,795.00

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 12/01/13 THROUGH 11/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	234,407.64	0.00	OTHER LAB	2,418.00	0.00
MED/SURG SUPPLY	114,587.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	158,953.67	0.00	EDUCATION & TRAINING	2,044.02	0.00
RADIOLOGY-DIAGNOSTIC	16,066.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	33,594.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	13,674.00	0.00	MRI SERVICES	4,461.00	0.00
IV THERAPY	10,444.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	358,601.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	135,700.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	50,983.51	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	11,319.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	42,650.00	0.00	SPECIAL SERVICES	0.00	600.00
RECOVERY ROOM	20,600.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	10,206.50	0.00	INJECTABLE DRUGS	39,059.58	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	300.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	19,495.00	0.00			
BLOOD	0.00	8,590.68			
BLOOD STORAGE & PRO.	0.00	3,600.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	4,140.00			
CARDIOLOGY	9,810.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	375.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,452.00	0.00			
			TOTAL ANCILLARY	1,292,201.17	16,930.68
			TOTAL ACCOMODATIONS	354,500.00	79,795.00
			TOTAL CHARGES	1,646,701.17	96,725.68

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

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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	12/01/13	THROUGH	11/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:31:27
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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 12/01/13 THROUGH 11/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,277,966.08	ADJUSTMENTS	139,880.77
COVERED CHARGES	2,104,594.52	CONTRACTUAL ALLOW	1,585,327.81
NON-COVERD CHARGES	173,371.56	TOTAL MEDICAID LIAB	519,266.71
		LESS: COB	63.85
		LESS: COPAYMENT	1,521.00
		REIMBURSEMENT	517,681.86
		ALL OTHER	459,060.58
		FEE SCHEDULE-LAB	55,636.94
		INJECTABLE DRUGS	2,984.34
		TOTAL NUMBER OF CLAIMS	1,012

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 12/01/13 THROUGH 11/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	127,549.76	0.00	OTHER LAB	2,127.00	0.00
MED/SURG SUPPLY	81,909.99	8.35	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	3,227.40
RADIOLOGY-DIAGNOSTIC	50,720.16	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	68,156.00	10,206.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	293,705.85	74,505.93
EKG/ECG	33,708.00	954.00	MRI SERVICES	17,483.00	0.00
IV THERAPY	124,936.00	5,580.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	813,269.60	65,053.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	29,113.78	2,147.88	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	31,987.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	154,300.00	900.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	41,200.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	1.00	INJECTABLE DRUGS	11,949.38	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,850.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	600.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	72,027.00	5,904.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	16,350.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	35,150.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	98,952.00	1,934.00			
			TOTAL ANCILLARY	2,104,594.52	172,871.56
			TOTAL ACCOMODATIONS	0.00	500.00
			TOTAL CHARGES	2,104,594.52	173,371.56

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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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 12/01/13 THROUGH 11/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	40,408.70	ADJUSTMENTS	0.00
COVERED CHARGES	27,484.16	CONTRACTUAL ALLOW	4,253.21
NON-COVERD CHARGES	12,924.54	TOTAL MEDICAID LIAB	23,230.95
		LESS: COB	23,230.95
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 6

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 12/01/13 THROUGH 11/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,335.82	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,132.37	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	53.79
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,729.77	48.75
EKG/ECG	159.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,290.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,079.00	12,772.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	80.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,753.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,350.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,236.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	71.20	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	1,512.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,756.00	50.00			
			TOTAL ANCILLARY	27,484.16	12,924.54
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	27,484.16	12,924.54

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 12/01/13 THROUGH 11/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,478.18	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,067.48	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	53.79
RADIOLOGY-DIAGNOSTIC	4,673.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,856.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,633.10	1,852.96
EKG/ECG	636.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,630.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,367.39	100.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	42,350.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,701.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	710.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,570.00	0.00			
			TOTAL ANCILLARY	79,672.15	2,006.75
			TOTAL ACCOMODATIONS	0.00	500.00
			TOTAL CHARGES	79,672.15	2,506.75

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	12/01/13	THROUGH	11/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 12/01/13 THROUGH 11/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	180,895.27	ADJUSTMENTS	10,707.10
COVERED CHARGES	179,774.80	CONTRACTUAL ALLOW	142,649.48
NON-COVERD CHARGES	1,120.47	TOTAL MEDICAID LIAB	37,125.32
		LESS: COB	0.00
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	37,092.32
		TOTAL NUMBER OF CLAIMS	7

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 12/01/13 THROUGH 11/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,256.08	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	50,238.16	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	161.37
RADIOLOGY-DIAGNOSTIC	374.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,089.56	959.10
EKG/ECG	318.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	111,272.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	2,884.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	343.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	179,774.80	1,120.47
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	179,774.80	1,120.47

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	12/01/13	THROUGH	11/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

JASPER MEMORIAL HOSP
 898 COLLEGE ST
 MONTICELLO,GA 31064-1258

PROVIDER NUMBER 000000998A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,786.91	ADJUSTMENTS	0.00
COVERED CHARGES	27,786.91	CONTRACTUAL ALLOW	10,228.62
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	17,558.29
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	17,558.29

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	11		0	4,023.25		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	11		0	4,023.25		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	11		0	4,023.25		0.00

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,325.80	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,291.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,203.10	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	934.17	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,166.90	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	201.94	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	608.34	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	1,913.25	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	1,662.82	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	5,624.45	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	62.93	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	768.66	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	23,763.66	0.00
			TOTAL ACCOMODATIONS	4,023.25	0.00
			TOTAL CHARGES	27,786.91	0.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:31:40
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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Page: 4

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	347,314.20	ADJUSTMENTS	19,329.31
COVERED CHARGES	304,032.41	CONTRACTUAL ALLOW	138,621.74
NON-COVERD CHARGES	43,281.79	TOTAL MEDICAID LIAB	165,410.67
		LESS: COB	32.74
		LESS: COPAYMENT	678.00
		REIMBURSEMENT	164,699.93
		ALL OTHER	148,409.29
		FEE SCHEDULE-LAB	13,739.31
		INJECTABLE DRUGS	2,551.33

TOTAL NUMBER OF CLAIMS 595

Report : CLM-0804-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:31:40
 Page: 5

JASPER MEMORIAL HOSP
 898 COLLEGE ST
 MONTICELLO,GA 31064-1258

PROVIDER NUMBER
 000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,602.39	35.77	OTHER LAB	1,350.18	0.00
MED/SURG SUPPLY	6,424.27	156.86	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,571.80	109.87	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	57,449.20	11,243.55	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	97,639.46	25,419.96
EKG/ECG	4,755.72	0.00	MRI SERVICES	7,168.00	0.00
IV THERAPY	14,010.53	82.38	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,411.31	127.95	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	64,176.40	123.57	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,862.80	4,908.95
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	7,408.30	883.86	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,253.68	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,844.20	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	3,104.17	189.07			
			TOTAL ANCILLARY	304,032.41	43,281.79
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	304,032.41	43,281.79

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,870.44	ADJUSTMENTS	0.00
COVERED CHARGES	21,252.93	CONTRACTUAL ALLOW	18,352.93
NON-COVERD CHARGES	1,617.51	TOTAL MEDICAID LIAB	2,900.00
		LESS: COB	0.00
		LESS: COPAYMENT	75.00
		REIMBURSEMENT	2,825.00
		TOTAL NUMBER OF CLAIMS	58

Report : CLM-0808-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	625.45	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	405.69	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	416.16	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,286.57	957.05
EKG/ECG	504.85	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,339.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	594.10	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	11,245.17	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	974.66	660.46
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	361.46	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	499.57	0.00			
			TOTAL ANCILLARY	21,252.93	1,617.51
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	21,252.93	1,617.51

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:31:41
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JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:31:48
 Page: 1

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	947,060.95	ADJUSTMENTS	0.00
COVERED CHARGES	937,038.95	CONTRACTUAL ALLOW	602,449.19
NON-COVERD CHARGES	10,022.00	TOTAL MEDICAID LIAB	334,589.76
		LESS: COB	2,263.45
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	332,326.31
		TOTAL NUMBER OF ADMISSIONS	64

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	209		0	94,050.00		10,000.00
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	209		0	94,050.00		10,000.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	47		0	47,000.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	47		0	47,000.00		0.00
TOTAL ACCOMODATIONS	256		0	141,050.00		10,000.00

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	306,296.95	0.00	OTHER LAB	2,536.00	0.00
MED/SURG SUPPLY	109,574.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	145,158.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,354.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	57,829.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,848.00	0.00	MRI SERVICES	5,600.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,678.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	72,588.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	32,615.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	495.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,404.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	19,235.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,800.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,250.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,728.00	22.00			
			TOTAL ANCILLARY	795,988.95	22.00
			TOTAL ACCOMODATIONS	141,050.00	10,000.00
			TOTAL CHARGES	937,038.95	10,022.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:31:49
Page: 4

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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,062,405.10	ADJUSTMENTS	12,531.68
COVERED CHARGES	919,508.00	CONTRACTUAL ALLOW	639,545.90
NON-COVERD CHARGES	142,897.10	TOTAL MEDICAID LIAB	279,962.10
		LESS: COB	33.43
		LESS: COPAYMENT	1,260.00
		REIMBURSEMENT	278,668.67
		ALL OTHER	246,224.45
		FEE SCHEDULE-LAB	31,454.81
		INJECTABLE DRUGS	989.41
		TOTAL NUMBER OF CLAIMS	1,120

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47,008.50	1,252.00	OTHER LAB	31,406.00	0.00
MED/SURG SUPPLY	58,380.00	153.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	127.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	76,445.00	5,916.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	184,399.00	9,612.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	236,395.20	56,253.80
EKG/ECG	9,632.00	784.00	MRI SERVICES	37,200.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,678.00	10,000.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,271.00	6,073.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	13,091.00	1,320.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	164,467.00	14,478.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	495.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18,393.30	12,836.30
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	3,500.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	19,697.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,125.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,400.00	2,400.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,250.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,275.00	21,692.00			
			TOTAL ANCILLARY	919,508.00	142,897.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	919,508.00	142,897.10

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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Page: 6

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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,049.00	ADJUSTMENTS	0.00
COVERED CHARGES	5,517.00	CONTRACTUAL ALLOW	1,712.04
NON-COVERD CHARGES	2,532.00	TOTAL MEDICAID LIAB	3,804.96
		LESS: COB	3,804.96
		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

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	342.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	847.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	524.00	124.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,954.00	421.00
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	812.00	444.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	927.00	920.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	315.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	308.00			
			TOTAL ANCILLARY	5,517.00	2,532.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,517.00	2,532.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	120,527.75	ADJUSTMENTS	426.00
COVERED CHARGES	116,847.75	CONTRACTUAL ALLOW	106,297.75
NON-COVERD CHARGES	3,680.00	TOTAL MEDICAID LIAB	10,550.00
		LESS: COB	0.00
		LESS: COPAYMENT	444.00
		REIMBURSEMENT	10,106.00
		TOTAL NUMBER OF CLAIMS	211

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,929.00	72.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,364.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,883.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,576.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	25,560.00	1,385.00
EKG/ECG	560.00	0.00	MRI SERVICES	1,800.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	900.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	63,918.00	356.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,862.75	1,163.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	495.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	704.00			
			TOTAL ANCILLARY	116,847.75	3,680.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	116,847.75	3,680.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

JEFFERSON HOSPITAL
 1067 PEACHTREE ST
 LOUISVILLE,GA 30434-1558

PROVIDER NUMBER 000001031A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	311,201.35	ADJUSTMENTS	12,473.84
COVERED CHARGES	303,938.35	CONTRACTUAL ALLOW	26,481.21
NON-COVERD CHARGES	7,263.00	TOTAL MEDICAID LIAB	277,457.14
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	277,457.14

TOTAL NUMBER OF ADMISSIONS 37

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	131		0	52,400.00		75.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	131		0	52,400.00		75.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	131		0	52,400.00		75.00

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35,579.00	0.00	OTHER LAB	762.00	0.00
MED/SURG SUPPLY	16,248.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	56,150.50	0.00	EDUCATION & TRAINING	503.60	0.00
RADIOLOGY-DIAGNOSTIC	8,424.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	25,888.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,220.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,508.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,296.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,936.50	940.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,445.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	308.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	34,802.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	29,077.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,259.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	298.00	0.00			
BLOOD	6,633.00	0.00			
BLOOD STORAGE & PRO.	6,030.00	6,248.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,150.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	20.00	0.00			
			TOTAL ANCILLARY	251,538.35	7,188.00
			TOTAL ACCOMODATIONS	52,400.00	75.00
			TOTAL CHARGES	303,938.35	7,263.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:32:02
Page: 4

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	835,313.48	ADJUSTMENTS	10,998.85
COVERED CHARGES	734,641.98	CONTRACTUAL ALLOW	457,849.98
NON-COVERD CHARGES	100,671.50	TOTAL MEDICAID LIAB	276,792.00
		LESS: COB	175.25
		LESS: COPAYMENT	1,455.00
		REIMBURSEMENT	275,161.75
		ALL OTHER	232,734.40
		FEE SCHEDULE-LAB	40,637.63
		INJECTABLE DRUGS	1,789.72
		TOTAL NUMBER OF CLAIMS	1,287

JEFFERSON HOSPITAL
 1067 PEACHTREE ST
 LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
 000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,781.00	4,242.00	OTHER LAB	27,106.00	0.00
MED/SURG SUPPLY	12,487.73	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	59,128.00	2,007.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	52,024.00	20,933.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,723.00	211.00	FEE SCHEDULE LAB	205,202.00	48,802.00
EKG/ECG	16,785.50	1,294.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,872.00	8,232.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	34,839.25	1,920.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,743.00	652.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	968.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	216,934.50	3,052.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,008.00	3,740.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	28,522.00	1,755.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	32,726.00	550.00			
BLOOD	3,618.00	0.00			
BLOOD STORAGE & PRO.	3,618.00	2,343.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,900.00	937.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,656.00	0.00			
			TOTAL ANCILLARY	734,641.98	100,671.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	734,641.98	100,671.50

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:32:08
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,338.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,778.75	CONTRACTUAL ALLOW	1,636.05
NON-COVERD CHARGES	559.25	TOTAL MEDICAID LIAB	1,142.70
		LESS: COB	1,139.70
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 4

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	22.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	88.00	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	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,098.00	412.00
EKG/ECG	80.50	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	8.25	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	932.00	117.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	134.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	162.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,778.75	559.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,778.75	559.25

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

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JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	68,787.50	ADJUSTMENTS	55.94
COVERED CHARGES	66,217.50	CONTRACTUAL ALLOW	59,225.00
NON-COVERD CHARGES	2,570.00	TOTAL MEDICAID LIAB	6,992.50
		LESS: COB	0.00
		LESS: COPAYMENT	186.00
		REIMBURSEMENT	6,806.50
		TOTAL NUMBER OF CLAIMS	125

Report : CLM-0808-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	640.00	172.00	OTHER LAB	298.00	0.00
MED/SURG SUPPLY	545.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,721.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,848.00	694.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	14,533.00	1,531.00
EKG/ECG	975.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	113.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	229.50	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	40,274.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,743.00	173.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	298.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	66,217.50	2,570.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	66,217.50	2,570.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	490.00	ADJUSTMENTS	0.00
COVERED CHARGES	490.00	CONTRACTUAL ALLOW	294.66
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	195.34
		LESS: COB	192.34
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27.00	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	457.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	490.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	490.00	0.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,480.73	ADJUSTMENTS	0.00
COVERED CHARGES	13,296.73	CONTRACTUAL ALLOW	7,912.93
NON-COVERD CHARGES	184.00	TOTAL MEDICAID LIAB	5,383.80
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	5,380.80
		TOTAL NUMBER OF CLAIMS	1

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	564.00	92.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,941.73	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	10,461.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	308.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22.00	92.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	13,296.73	184.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,296.73	184.00

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

JENKINS COUNTY HOSPITAL
 931 E WINTHROPE AVE
 MILLEN,GA 30442-1839

PROVIDER NUMBER 000001042A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	377,651.91	ADJUSTMENTS	0.00
COVERED CHARGES	215,922.75	CONTRACTUAL ALLOW	74,780.48
NON-COVERD CHARGES	161,729.16	TOTAL MEDICAID LIAB	141,142.27
		LESS: COB	1,672.48
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	139,469.79

TOTAL NUMBER OF ADMISSIONS 35

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	67		0	50,183.00		154,187.56
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	67		0	50,183.00		154,187.56
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	67		0	50,183.00		154,187.56

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

JENKINS COUNTY HOSPITAL
 931 E WINTHROPE AVE
 MILLEN,GA 30442-1839

PROVIDER NUMBER
 000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48,780.85	0.00	OTHER LAB	3,334.00	0.00
MED/SURG SUPPLY	10,258.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	34,854.96	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,376.40	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,727.10	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	632.16	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,104.10	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,738.74	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	17,908.69	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,479.30	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,602.45	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,321.60	7,541.60			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,918.20	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	702.80	0.00			
			TOTAL ANCILLARY	165,739.75	7,541.60
			TOTAL ACCOMODATIONS	50,183.00	154,187.56
			TOTAL CHARGES	215,922.75	161,729.16

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

JENKINS COUNTY HOSPITAL
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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JENKINS COUNTY HOSPITAL
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,567,822.67	ADJUSTMENTS	21,349.78
COVERED CHARGES	1,417,750.02	CONTRACTUAL ALLOW	1,007,298.43
NON-COVERD CHARGES	150,072.65	TOTAL MEDICAID LIAB	410,451.59
		LESS: COB	166.59
		LESS: COPAYMENT	1,197.00
		REIMBURSEMENT	409,088.00
		ALL OTHER	225,657.67
		FEE SCHEDULE-LAB	183,430.33
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	2,246

JENKINS COUNTY HOSPITAL
 931 E WINTHROPE AVE
 MILLEN,GA 30442-1839

PROVIDER NUMBER
 000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	67,046.85	996.00	OTHER LAB	5,377.51	0.00
MED/SURG SUPPLY	8,044.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	52,198.35	846.35	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	46,718.85	4,372.20	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	12,842.28	14,636.47	FEE SCHEDULE LAB	667,264.33	28,307.25
EKG/ECG	12,731.50	517.35	MRI SERVICES	0.00	0.00
IV THERAPY	17,030.16	2,525.52	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	322,552.38	80,983.08	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,872.92	2,849.78	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	149,088.64	11,501.30	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,208.00	965.10			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	915.20	592.70			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	16,283.50	979.55			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,574.75	0.00			
			TOTAL ANCILLARY	1,417,750.02	150,072.65
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,417,750.02	150,072.65

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JENKINS COUNTY HOSPITAL
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,840.79	ADJUSTMENTS	0.00
COVERED CHARGES	12,737.77	CONTRACTUAL ALLOW	7,980.28
NON-COVERD CHARGES	14,103.02	TOTAL MEDICAID LIAB	4,757.49
		LESS: COB	4,742.49
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 14

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JENKINS COUNTY HOSPITAL
 931 E WINTHROPE AVE
 MILLEN,GA 30442-1839

PROVIDER NUMBER
 000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	588.95	370.80	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	153.65	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,013.28	451.20
EKG/ECG	344.90	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,322.84	12,968.52	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,810.60	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	979.55	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	524.00	312.50			
			TOTAL ANCILLARY	12,737.77	14,103.02
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,737.77	14,103.02

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

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JENKINS COUNTY HOSPITAL
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	68,294.45	ADJUSTMENTS	0.00
COVERED CHARGES	66,670.89	CONTRACTUAL ALLOW	58,670.89
NON-COVERD CHARGES	1,623.56	TOTAL MEDICAID LIAB	8,000.00
		LESS: COB	0.00
		LESS: COPAYMENT	270.00
		REIMBURSEMENT	7,730.00
		TOTAL NUMBER OF CLAIMS	160

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

JENKINS COUNTY HOSPITAL
 931 E WINTHROPE AVE
 MILLEN,GA 30442-1839

PROVIDER NUMBER
 000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,338.15	0.00	OTHER LAB	539.90	0.00
MED/SURG SUPPLY	205.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,395.40	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,266.45	843.35	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,560.16	426.72
EKG/ECG	862.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	155.91	353.49	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	236.50	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	44,373.22	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	585.30	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	152.65	0.00			
			TOTAL ANCILLARY	66,670.89	1,623.56
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	66,670.89	1,623.56

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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JENKINS COUNTY HOSPITAL
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	574.84	ADJUSTMENTS	0.00
COVERED CHARGES	562.84	CONTRACTUAL ALLOW	377.94
NON-COVERD CHARGES	12.00	TOTAL MEDICAID LIAB	184.90
		LESS: COB	184.90
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JENKINS COUNTY HOSPITAL
 931 E WINTHROPE AVE
 MILLEN,GA 30442-1839

PROVIDER NUMBER
 000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 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	243.29	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	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	562.84	12.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	562.84	12.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JENKINS COUNTY HOSPITAL
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JENKINS COUNTY HOSPITAL
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF 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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,931,067.51	ADJUSTMENTS	391,542.88
COVERED CHARGES	11,152,018.51	CONTRACTUAL ALLOW	7,455,860.88
NON-COVERD CHARGES	779,049.00	TOTAL MEDICAID LIAB	3,696,157.63
		LESS: COB	61,420.39
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,634,737.24

TOTAL NUMBER OF ADMISSIONS 433

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,412		2	1,458,974.00		697,085.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		7,409.00
TOTAL ROUTINE	1,412		2	1,458,974.00		704,494.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	572		0	1,445,174.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		14	0.00		17,724.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	572		14	1,445,174.00		17,724.00
TOTAL ACCOMODATIONS	1,984		16	2,904,148.00		722,218.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	876,823.00	80.00	OTHER LAB	135,478.00	0.00
MED/SURG SUPPLY	41,658.00	3,488.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,027,890.00	2,728.00	EDUCATION & TRAINING	4,784.00	70.00
RADIOLOGY-DIAGNOSTIC	376,347.00	0.00	OTHER THERAPEUTIC SVC	0.00	847.00
CT SCAN	740,183.00	25,913.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	49,174.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	217,021.00	0.00	MRI SERVICES	107,654.00	0.00
IV THERAPY	11,951.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	703,875.00	1,041.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	421,011.00	2,139.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	153,513.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	59,734.00	1,790.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,264,159.00	3,706.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	122,525.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	90,891.00	0.00	INJECTABLE DRUGS	589,115.51	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	12,407.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	13,757.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	508,174.00	7,290.00	PATIENT CONVENIENCE	0.00	558.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	59.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	178,184.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,363.00
OTHER IMAGING SERVICE	77,938.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	42,123.00	4,818.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	143,377.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	241,836.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	26,257.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,972.00	0.00			
			TOTAL ANCILLARY	8,247,870.51	56,831.00
			TOTAL ACCOMODATIONS	2,904,148.00	722,218.00
			TOTAL CHARGES	11,152,018.51	779,049.00

Report : CLM-0800-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013316075021	10/20/13 - 10/21/13	11/18/13	0.00	2,363.00	0.00	0.00	0.00
TOTAL				0.00	2,363.00	0.00	0.00	0.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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WINNETT 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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,805,051.75	ADJUSTMENTS	150,693.60
COVERED CHARGES	6,120,829.26	CONTRACTUAL ALLOW	4,905,484.32
NON-COVERD CHARGES	684,222.49	TOTAL MEDICAID LIAB	1,215,344.94
		LESS: COB	123.27
		LESS: COPAYMENT	1,899.00
		REIMBURSEMENT	1,213,322.67
		ALL OTHER	1,129,317.65
		FEE SCHEDULE-LAB	76,298.93
		INJECTABLE DRUGS	7,706.09

TOTAL NUMBER OF CLAIMS 2,255

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	191,833.00	32,981.00	OTHER LAB	110,817.00	0.00
MED/SURG SUPPLY	26,853.00	4,240.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,811.00	EDUCATION & TRAINING	0.00	210.00
RADIOLOGY-DIAGNOSTIC	432,917.00	2,260.00	OTHER THERAPEUTIC SVC	0.00	5,566.00
CT SCAN	652,704.00	138,209.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,204.00	544.00	FEE SCHEDULE LAB	831,556.00	109,678.90
EKG/ECG	100,875.00	1,898.00	MRI SERVICES	239,073.00	27,138.00
IV THERAPY	57,564.00	12,244.00	PROFESSIONAL FEES	0.00	129.00
OPERATING ROOM	614,320.15	117,267.85	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	14,271.00	10,598.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	145,084.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	170,534.00	11,040.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,748,456.00	27,392.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	168,185.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	1,006.00	INJECTABLE DRUGS	99,737.00	49,550.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	122.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,756.00	732.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	19,416.00	PATIENT CONVENIENCE	0.00	4.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	295.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,959.00	43,114.74
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	4,726.00
OTHER IMAGING SERVICE	248,865.11	37,543.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	16,912.00	12,441.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	107,890.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	65,552.00	11,072.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,211.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	68,701.00	894.00			
			TOTAL ANCILLARY	6,120,829.26	684,122.49
			TOTAL ACCOMODATIONS	0.00	100.00
			TOTAL CHARGES	6,120,829.26	684,222.49

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014189041941	12/02/13 - 12/02/13	07/14/14	0.00	2,363.00	0.00	0.00	0.00
615	5014216965035	04/18/14 - 04/18/14	08/18/14	0.00	2,363.00	0.00	0.00	0.00
TOTAL				0.00	4,726.00	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WINNETT 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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	72,461.00	ADJUSTMENTS	0.00
COVERED CHARGES	59,164.00	CONTRACTUAL ALLOW	39,808.95
NON-COVERD CHARGES	13,297.00	TOTAL MEDICAID LIAB	19,355.05
		LESS: COB	19,334.81
		LESS: COPAYMENT	20.24
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 23

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,037.00	0.00	OTHER LAB	1,098.00	0.00
MED/SURG SUPPLY	0.00	28.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	132.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,692.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,134.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	824.00	FEE SCHEDULE LAB	6,863.00	1,442.00
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	10,390.00	5,796.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,387.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,642.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,744.00	1,273.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,372.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,462.00	134.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	386.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	514.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	233.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	407.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,010.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,565.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,146.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	59,164.00	13,297.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	59,164.00	13,297.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	324,245.00	ADJUSTMENTS	379.58
COVERED CHARGES	311,833.00	CONTRACTUAL ALLOW	294,379.72
NON-COVERD CHARGES	12,412.00	TOTAL MEDICAID LIAB	17,453.28
		LESS: COB	0.00
		LESS: COPAYMENT	492.00
		REIMBURSEMENT	16,961.28
		TOTAL NUMBER OF CLAIMS	312

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,195.00	1,200.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	538.00	463.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,727.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,887.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	35,646.00	7,822.00
EKG/ECG	3,000.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	623.00	89.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	228,610.00	1,054.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,216.00	1,283.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,391.00	501.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	311,833.00	12,412.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	311,833.00	12,412.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	876.00	ADJUSTMENTS	0.00
COVERED CHARGES	876.00	CONTRACTUAL ALLOW	563.10
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	312.90
		LESS: COB	309.90
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 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	417.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	459.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	876.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	876.00	0.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	310,759.00	ADJUSTMENTS	30,020.05
COVERED CHARGES	295,001.00	CONTRACTUAL ALLOW	223,712.24
NON-COVERD CHARGES	15,758.00	TOTAL MEDICAID LIAB	71,288.76
		LESS: COB	0.00
		LESS: COPAYMENT	39.00
		REIMBURSEMENT	71,249.76
		TOTAL NUMBER OF CLAIMS	12

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,850.00	700.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,962.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,304.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,327.00	0.00
EKG/ECG	750.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,900.00	700.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	119,217.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	178.00	89.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	27,642.00	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	16,731.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	94,818.00	1,141.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	118.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	9,979.00	13,010.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,343.00	0.00			
			TOTAL ANCILLARY	295,001.00	15,758.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	295,001.00	15,758.00

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

HUTCHESON MEDICAL CENTER
 100 GROSS CRESCENT CIR
 FORT OGLETHORPE, GA 30742-3643

PROVIDER NUMBER 000001075A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,945,708.48	ADJUSTMENTS	309,193.62
COVERED CHARGES	5,785,551.03	CONTRACTUAL ALLOW	4,112,153.20
NON-COVERD CHARGES	160,157.45	TOTAL MEDICAID LIAB	1,673,397.83
		LESS: COB	12,116.82
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,661,281.01

TOTAL NUMBER OF ADMISSIONS 209

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	684		0	523,833.00		97,431.00
ROUTINE NURSERY	32		0	19,908.00		3,548.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	716		0	543,741.00		100,979.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	226		0	376,516.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	226		0	376,516.00		0.00
TOTAL ACCOMODATIONS	942		0	920,257.00		100,979.00

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

HUTCHESON MEDICAL CENTER
 100 GROSS CRESCENT CIR
 FORT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
 000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,148,102.92	6,566.55	OTHER LAB	17,414.00	0.00
MED/SURG SUPPLY	161,611.25	1,049.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,128,964.96	9,745.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	116,156.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	277,860.00	16,178.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	29,603.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	82,812.00	0.00	MRI SERVICES	15,599.00	0.00
IV THERAPY	154,553.00	3,612.00	PROFESSIONAL FEES	0.00	177.00
OPERATING ROOM	238,851.00	8,871.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	21,414.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	556,867.00	3,328.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	17,517.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	20,718.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	315,829.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	30,246.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	13,520.00	0.00	INJECTABLE DRUGS	93,981.88	0.00
RADIOLOGY THERAPEUTIC	50,636.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,916.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	4,380.00	876.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	400.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	10,264.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	27,054.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	58,963.00	1,256.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	54,202.00	7,519.00			
AUDIOLOGY	744.00	0.00			
CARDIOLOGY	132,591.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	80,524.00	0.00			
			TOTAL ANCILLARY	4,865,294.03	59,178.45
			TOTAL ACCOMODATIONS	920,257.00	100,979.00
			TOTAL CHARGES	5,785,551.03	160,157.45

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

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

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SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

HUTCHESON MEDICAL CENTER
 100 GROSS CRESCENT CIR
 FORT OGLETHORPE, GA 30742-3643

PROVIDER NUMBER
 000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	73,432.39	ADJUSTMENTS	0.00
COVERED CHARGES	72,348.39	CONTRACTUAL ALLOW	41,672.31
NON-COVERD CHARGES	1,084.00	TOTAL MEDICAID LIAB	30,676.08
		LESS: COB	30,676.08
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	11		0	8,613.00		1,084.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	11		0	8,613.00		1,084.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	4		0	6,664.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	6,664.00		0.00
TOTAL ACCOMODATIONS	15		0	15,277.00		1,084.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

HUTCHESON MEDICAL CENTER
 100 GROSS CRESCENT CIR
 FORT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
 000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,053.76	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	801.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	20,695.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,934.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,341.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	618.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,770.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,226.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,178.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,792.63	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	662.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	57,071.39	0.00
			TOTAL ACCOMODATIONS	15,277.00	1,084.00
			TOTAL CHARGES	72,348.39	1,084.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIR
FORT OGLETHORPE, GA 30742-3643

PROVIDER NUMBER
000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,805,825.42	ADJUSTMENTS	615,239.31
COVERED CHARGES	9,128,146.73	CONTRACTUAL ALLOW	7,213,518.64
NON-COVERD CHARGES	677,678.69	TOTAL MEDICAID LIAB	1,914,628.09
		LESS: COB	15,168.18
		LESS: COPAYMENT	5,955.38
		REIMBURSEMENT	1,893,504.53
		ALL OTHER	1,581,868.88
		FEE SCHEDULE-LAB	138,199.68
		INJECTABLE DRUGS	173,435.97

TOTAL NUMBER OF CLAIMS 4,478

Report : CLM-0804-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:32:58
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HUTCHESON MEDICAL CENTER
 100 GROSS CRESCENT CIR
 FORT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
 000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	314,376.53	2,647.16	OTHER LAB	48,433.00	446.00
MED/SURG SUPPLY	81,600.46	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	128.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	310,520.00	1,922.00	OTHER THERAPEUTIC SVC	0.00	1,805.00
CT SCAN	675,302.00	38,279.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	50,809.00	11,810.04	FEE SCHEDULE LAB	1,331,133.80	321,746.58
EKG/ECG	166,276.00	6,489.00	MRI SERVICES	70,882.00	0.00
IV THERAPY	599,959.00	95,644.00	PROFESSIONAL FEES	0.00	295.00
OPERATING ROOM	290,547.34	38,742.66	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	132,289.90	8,630.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	68,159.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	103,483.85	12,181.17	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,043,236.02	4,840.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	155,195.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,380,005.78	77,019.76
RADIOLOGY THERAPEUTIC	501,913.00	2,434.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	642.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,226.00	2,260.03	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	94,592.00	7,885.20	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	722.00	0.00	IMPL DEV CHARGE PATIENTS	25,893.04	2,413.09
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	114.00
OTHER IMAGING SERVICE	76,107.00	1,374.00			
BLOOD	0.00	2,484.00			
BLOOD STORAGE & PRO.	72,531.00	1,242.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	194,542.00	27,426.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	158,689.00	595.00			
AMBULATORY SURGERY	78,971.01	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	979.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	98,131.00	5,923.00			
			TOTAL ANCILLARY	9,128,146.73	676,775.69
			TOTAL ACCOMODATIONS	0.00	903.00
			TOTAL CHARGES	9,128,146.73	677,678.69

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:32:58
Page: 7

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIR
FORT OGLETHORPE, GA 30742-3643

PROVIDER NUMBER
000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5913312000112	10/17/13 - 10/17/13	11/11/13	0.00	114.00	0.00	0.00	0.00
TOTAL				0.00	114.00	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:33:11
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SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIR
FORT OGLETHORPE, GA 30742-3643

PROVIDER NUMBER
000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	179,554.72	ADJUSTMENTS	0.00
COVERED CHARGES	160,403.23	CONTRACTUAL ALLOW	109,743.43
NON-COVERD CHARGES	19,151.49	TOTAL MEDICAID LIAB	50,659.80
		LESS: COB	50,584.80
		LESS: COPAYMENT	75.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 48

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HUTCHESON MEDICAL CENTER PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
 100 GROSS CRESCENT CIR 000001075A SERVICE DATES 10/01/13 THROUGH 09/30/14
 FORT OGLETHORPE,GA 30742-3643 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,127.51	937.35	OTHER LAB	492.00	0.00
MED/SURG SUPPLY	2,018.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,835.00	3,103.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,054.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,396.24	2,615.36
EKG/ECG	927.00	0.00	MRI SERVICES	6,780.00	4,333.00
IV THERAPY	7,559.00	759.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,556.00	2,930.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	143.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,428.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,490.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,674.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	35,462.48	1,237.78
RADIOLOGY THERAPEUTIC	43,461.00	2,755.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	481.00			
			TOTAL ANCILLARY	160,403.23	19,151.49
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	160,403.23	19,151.49

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:33:12
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HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIR
FORT OGLETHORPE, GA 30742-3643

PROVIDER NUMBER
000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	764,074.20	ADJUSTMENTS	3,392.22
COVERED CHARGES	746,308.38	CONTRACTUAL ALLOW	709,667.68
NON-COVERD CHARGES	17,765.82	TOTAL MEDICAID LIAB	36,640.70
		LESS: COB	0.00
		LESS: COPAYMENT	1,209.00
		REIMBURSEMENT	35,431.70
		TOTAL NUMBER OF CLAIMS	655

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

HUTCHESON MEDICAL CENTER
 100 GROSS CRESCENT CIR
 FORT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
 000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,307.98	155.65	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	840.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	47.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,151.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,647.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	101,224.20	12,451.00
EKG/ECG	9,270.00	309.00	MRI SERVICES	0.00	0.00
IV THERAPY	85,105.00	3,514.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,094.00	143.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	452,132.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	28,903.20	1,146.17
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	4,634.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	746,308.38	17,765.82
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	746,308.38	17,765.82

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:33:14
Page: 12

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIR
FORT OGLETHORPE, GA 30742-3643

PROVIDER NUMBER
000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,014.50	ADJUSTMENTS	0.00
COVERED CHARGES	21,161.05	CONTRACTUAL ALLOW	17,284.95
NON-COVERD CHARGES	853.45	TOTAL MEDICAID LIAB	3,876.10
		LESS: COB	3,864.10
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	12

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HUTCHESON MEDICAL CENTER
 100 GROSS CRESCENT CIR
 FORT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
 000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	494.58	119.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	774.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,037.72	661.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,843.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	684.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,540.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	463.75	73.45
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,324.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	21,161.05	853.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	21,161.05	853.45

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIR
FORT OGLETHORPE, GA 30742-3643

PROVIDER NUMBER
000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,659,055.72	ADJUSTMENTS	59,955.54
COVERED CHARGES	1,589,150.55	CONTRACTUAL ALLOW	1,381,840.46
NON-COVERD CHARGES	69,905.17	TOTAL MEDICAID LIAB	207,310.09
		LESS: COB	0.00
		LESS: COPAYMENT	573.00
		REIMBURSEMENT	206,737.09

TOTAL NUMBER OF CLAIMS 37

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUTCHESON MEDICAL CENTER	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
100 GROSS CRESCENT CIR	000001075A	SERVICE DATES	10/01/13	THROUGH	09/30/14
FORT OGLETHORPE,GA 30742-3643		ADMISSION DATES	00/00/00	THROUGH	00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,794.75	0.00	OTHER LAB	1,200.00	0.00
MED/SURG SUPPLY	25,151.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,284.00	304.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,931.00	3,341.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	701.02	FEE SCHEDULE LAB	21,742.20	6,862.40
EKG/ECG	0.00	0.00	MRI SERVICES	5,200.00	0.00
IV THERAPY	32,182.00	200.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	42,868.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,343.00	2,223.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	409.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,675.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	567.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	996,972.60	55,121.75
RADIOLOGY THERAPEUTIC	416,128.00	1,152.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,496.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	646.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	2,750.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,811.00	0.00			
			TOTAL ANCILLARY	1,589,150.55	69,905.17
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,589,150.55	69,905.17

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIR
FORT OGLETHORPE, GA 30742-3643

PROVIDER NUMBER
000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,743.82	ADJUSTMENTS	0.00
COVERED CHARGES	27,617.62	CONTRACTUAL ALLOW	20,136.78
NON-COVERD CHARGES	126.20	TOTAL MEDICAID LIAB	7,480.84
		LESS: COB	7,477.84
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUTCHESON MEDICAL CENTER	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
100 GROSS CRESCENT CIR	000001075A	SERVICE DATES	10/01/13	THROUGH	09/30/14
FORT OGLETHORPE,GA 30742-3643		ADMISSION DATES	00/00/00	THROUGH	00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	219.50	126.20	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	69.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	220.72	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	200.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	25,512.40	0.00
RADIOLOGY THERAPEUTIC	1,396.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	27,617.62	126.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	27,617.62	126.20

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,681,565.84	ADJUSTMENTS	258,047.26
COVERED CHARGES	14,498,754.24	CONTRACTUAL ALLOW	10,582,246.10
NON-COVERD CHARGES	182,811.60	TOTAL MEDICAID LIAB	3,916,508.14
		LESS: COB	8,223.86
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,908,284.28

TOTAL NUMBER OF ADMISSIONS 673

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,272		0	1,045,070.00		600.00
ROUTINE NURSERY	330		0	260,102.00		388.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,602		0	1,305,172.00		988.00
SPECIAL CARE SERVICES						
CCU	247		0	370,800.00		0.00
ICU	247		0	494,247.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	494		0	865,047.00		0.00
TOTAL ACCOMODATIONS	2,096		0	2,170,219.00		988.00

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	705,421.51	1,094.85	OTHER LAB	110,923.50	0.00
MED/SURG SUPPLY	627,680.91	773.36	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,216,900.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	251,571.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	787,222.50	751.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	81,588.50	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	306,522.50	0.00	MRI SERVICES	160,407.75	0.00
IV THERAPY	32,160.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,874,063.50	35,115.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	495,137.16	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	636,498.50	411.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	254,105.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	743,713.25	1,512.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	149,214.18	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	62,351.75	0.00	INJECTABLE DRUGS	1,254,988.93	0.00
RADIOLOGY THERAPEUTIC	17,246.76	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	10,307.25	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	22,860.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	2,154.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,370.00	8,680.89	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	190,311.79	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	22,266.00
OTHER IMAGING SERVICE	116,625.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	142,327.75	97,970.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	88,468.25	13,247.00			
AUDIOLOGY	155,618.75	0.00			
CARDIOLOGY	802,794.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	21,980.00	0.00			
			TOTAL ANCILLARY	12,328,535.24	181,823.60
			TOTAL ACCOMODATIONS	2,170,219.00	988.00
			TOTAL CHARGES	14,498,754.24	182,811.60

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013260036696	08/15/13 - 08/20/13	09/23/13	0.00	2,474.00	0.00	0.00	0.00
615	2013267066986	08/23/13 - 08/25/13	09/30/13	0.00	2,474.00	0.00	0.00	0.00
615	2013290074603	09/13/13 - 09/17/13	10/21/13	0.00	2,474.00	0.00	0.00	0.00
615	2013331095640	07/28/13 - 08/08/13	12/02/13	0.00	2,474.00	0.00	0.00	0.00
615	2213337008175	10/15/13 - 10/24/13	12/09/13	0.00	2,474.00	0.00	0.00	0.00
615	5214008027695	10/02/13 - 10/15/13	01/13/14	0.00	2,474.00	0.00	0.00	0.00
615	2014017078432	12/15/13 - 12/16/13	01/27/14	0.00	2,474.00	0.00	0.00	0.00
615	2014042050151	01/12/14 - 01/22/14	02/17/14	0.00	2,474.00	0.00	0.00	0.00
615	2014290066458	09/09/13 - 09/11/13	10/27/14	0.00	2,474.00	0.00	0.00	0.00
TOTAL				0.00	22,266.00	0.00	0.00	0.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,218.50	ADJUSTMENTS	0.00
COVERED CHARGES	3,218.50	CONTRACTUAL ALLOW	1,029.91
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	2,188.59
		LESS: COB	2,188.59
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	0		0	0.00		0.00
ROUTINE NURSERY	2		0	1,576.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2		0	1,576.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	2		0	1,576.00		0.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	35.36	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	306.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	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	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	213.89	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	89.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	889.25	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,642.50	0.00
			TOTAL ACCOMODATIONS	1,576.00	0.00
			TOTAL CHARGES	3,218.50	0.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,097,434.79	ADJUSTMENTS	385,523.79
COVERED CHARGES	14,288,515.35	CONTRACTUAL ALLOW	11,541,565.73
NON-COVERD CHARGES	1,808,919.44	TOTAL MEDICAID LIAB	2,746,949.62
		LESS: COB	651.21
		LESS: COPAYMENT	11,240.28
		REIMBURSEMENT	2,735,058.13
		ALL OTHER	2,377,061.31
		FEE SCHEDULE-LAB	210,245.09
		INJECTABLE DRUGS	147,751.73
		TOTAL NUMBER OF CLAIMS	6,336

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	101,059.64	4,491.97	OTHER LAB	101,333.00	0.00
MED/SURG SUPPLY	293,443.70	8,531.99	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	183.75	0.00
RADIOLOGY-DIAGNOSTIC	719,387.25	24,894.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,685,813.75	161,106.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	36,559.50	12,758.88	FEE SCHEDULE LAB	2,465,663.98	526,553.35
EKG/ECG	160,247.50	630.50	MRI SERVICES	850,611.00	8,428.00
IV THERAPY	325,281.00	1,314.50	PROFESSIONAL FEES	0.00	230.00
OPERATING ROOM	1,798,359.75	184,771.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	82,001.75	5,704.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	263,175.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,195,524.75	37,988.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	161,076.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	779,927.76	222,641.70
RADIOLOGY THERAPEUTIC	283,124.85	773.25	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	16,406.75	11,670.77	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,082.50	8,086.81	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	436,538.51	12,437.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	23,090.31	55,709.51
LITHOTRIPSY	42,281.00	0.00	NO CC/INVALID REV CODE	0.00	8,095.71
OTHER IMAGING SERVICE	454,145.50	25,113.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	33,482.50	970.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	351,593.00	98,161.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	285,024.50	382,982.50			
AMBULATORY SURGERY	14,340.25	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	252,519.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	72,236.25	4,667.75			
			TOTAL ANCILLARY	14,288,515.35	1,808,712.19
			TOTAL ACCOMODATIONS	0.00	207.25
			TOTAL CHARGES	14,288,515.35	1,808,919.44

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5913238001242	07/17/13 - 07/17/13	09/02/13	0.00	2,474.00	0.00	0.00	0.00
615	2214057009835	08/11/13 - 08/11/13	03/03/14	0.00	2,474.00	0.00	0.00	0.00
615	2014090033537	03/12/14 - 03/12/14	04/07/14	0.00	2,474.00	0.00	0.00	0.00
3014	2214122016772	09/09/13 - 09/09/13	05/05/14	0.00	96.25	0.00	0.00	0.00
2469	2214288013266	09/06/13 - 09/30/13	10/20/14	0.00	445.20	0.00	0.00	0.00
9370	2215062012849	02/24/14 - 02/24/14	03/09/15	0.00	132.26	0.00	0.00	0.00
TOTAL				0.00	8,095.71	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	61,245.54	ADJUSTMENTS	0.00
COVERED CHARGES	26,779.36	CONTRACTUAL ALLOW	10,768.14
NON-COVERD CHARGES	34,466.18	TOTAL MEDICAID LIAB	16,011.22
		LESS: COB	15,978.22
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 17

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	401.72	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,698.33	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	395.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,681.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	3,974.50	FEE SCHEDULE LAB	3,352.25	738.00
EKG/ECG	315.25	0.00	MRI SERVICES	2,938.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	24,908.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,311.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,001.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,043.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,295.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	681.91	445.68
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	4,400.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,591.50	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	675.25	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	2,396.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	26,779.36	34,466.18
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	26,779.36	34,466.18

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	848,403.99	ADJUSTMENTS	1,697.07
COVERED CHARGES	817,276.45	CONTRACTUAL ALLOW	782,985.28
NON-COVERD CHARGES	31,127.54	TOTAL MEDICAID LIAB	34,291.17
		LESS: COB	0.00
		LESS: COPAYMENT	1,164.03
		REIMBURSEMENT	33,127.14
		TOTAL NUMBER OF CLAIMS	613

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,561.00	0.00	OTHER LAB	4,564.25	0.00
MED/SURG SUPPLY	8,351.16	57.16	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	48,743.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	42,235.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	153,770.25	14,665.25
EKG/ECG	10,403.25	0.00	MRI SERVICES	7,709.75	4,689.00
IV THERAPY	4,576.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,175.25	4,271.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,065.00	282.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,414.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	481,688.00	1,335.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,251.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	21,554.69	2,494.88
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	3,483.50	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	9,729.25	3,332.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	817,276.45	31,127.54
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	817,276.45	31,127.54

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,127.85	ADJUSTMENTS	0.00
COVERED CHARGES	2,127.85	CONTRACTUAL ALLOW	2,124.85
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

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 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	629.25	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,431.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	67.60	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	2,127.85	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,127.85	0.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,111,016.12	ADJUSTMENTS	132,015.97
COVERED CHARGES	1,902,604.89	CONTRACTUAL ALLOW	1,514,120.41
NON-COVERD CHARGES	208,411.23	TOTAL MEDICAID LIAB	388,484.48
		LESS: COB	0.00
		LESS: COPAYMENT	735.36
		REIMBURSEMENT	387,749.12

TOTAL NUMBER OF CLAIMS 71

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,883.94	1,798.98	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	99,179.28	1,990.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,048.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,948.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	704.00	FEE SCHEDULE LAB	89,314.82	30,385.88
EKG/ECG	1,891.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	111,629.75	2,692.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	415,428.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	76,604.00	56,394.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	67,707.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,469.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	17,760.70	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	478,402.71	40,832.51
RADIOLOGY THERAPEUTIC	98,243.62	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	35,547.50	206.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	22,835.82	51,429.21
LITHOTRIPSY	63,421.50	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	675.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,739.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,353.75	660.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	247,798.00	16,264.50			
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	19,722.00	5,052.50			
			TOTAL ANCILLARY	1,902,604.89	208,411.23
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,902,604.89	208,411.23

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL, INC
 201 HOSPITAL RD
 CANTON,GA 30114-2408

PROVIDER NUMBER 000001108A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,340,383.58	ADJUSTMENTS	833,739.62
COVERED CHARGES	15,544,016.08	CONTRACTUAL ALLOW	11,694,453.43
NON-COVERD CHARGES	796,367.50	TOTAL MEDICAID LIAB	3,849,562.65
		LESS: COB	22,557.28
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,827,005.37

TOTAL NUMBER OF ADMISSIONS 717

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,681		0	1,615,459.00		359,377.00
ROUTINE NURSERY	654		35	883,464.00		296,630.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,335		35	2,498,923.00		656,007.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	184		0	660,008.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	184		0	660,008.00		0.00
TOTAL ACCOMODATIONS	2,519		35	3,158,931.00		656,007.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL, INC
 201 HOSPITAL RD
 CANTON,GA 30114-2408

PROVIDER NUMBER
 000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,259,203.06	6,977.50	OTHER LAB	56,404.00	0.00
MED/SURG SUPPLY	807,064.50	8,775.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,216,984.37	35,075.00	EDUCATION & TRAINING	1,404.00	0.00
RADIOLOGY-DIAGNOSTIC	231,748.00	0.00	OTHER THERAPEUTIC SVC	0.00	1,168.00
CT SCAN	442,260.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	100,655.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	69,222.00	0.00	MRI SERVICES	119,908.00	0.00
IV THERAPY	70,152.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,025,110.00	11,854.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	878,870.00	2,689.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	641,178.00	1,079.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	152,155.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	448,239.00	15,135.00	SPECIAL SERVICES	0.00	13,429.00
RECOVERY ROOM	124,891.00	2,694.00	DRUG-SPECIFIC/HOME IV	0.00	23,266.00
LABORATORY PATHOLOGIC	78,321.00	0.00	INJECTABLE DRUGS	2,602,132.15	7,271.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	32,619.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	39,333.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	101,568.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	170.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	79,277.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	117,359.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	169,926.00	3,148.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	66,203.00	7,639.00			
AUDIOLOGY	82,375.00	0.00			
CARDIOLOGY	359,836.00	161.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,330.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,188.00	0.00			
			TOTAL ANCILLARY	12,385,085.08	140,360.50
			TOTAL ACCOMODATIONS	3,158,931.00	656,007.00
			TOTAL CHARGES	15,544,016.08	796,367.50

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL, INC
 201 HOSPITAL RD
 CANTON,GA 30114-2408

PROVIDER NUMBER 000001108A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	385,262.50	ADJUSTMENTS	0.00
COVERED CHARGES	362,032.50	CONTRACTUAL ALLOW	251,245.22
NON-COVERD CHARGES	23,230.00	TOTAL MEDICAID LIAB	110,787.28
		LESS: COB	110,787.28
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 17

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	48		12	46,176.00		20,568.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	48		12	46,176.00		20,568.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	48		12	46,176.00		20,568.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL, INC
 201 HOSPITAL RD
 CANTON,GA 30114-2408

PROVIDER NUMBER
 000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,972.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	14,330.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	42,942.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,364.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,286.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,008.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	897.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	20,385.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	52,888.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	768.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,564.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,687.00	0.00	SPECIAL SERVICES	0.00	2,662.00
RECOVERY ROOM	4,830.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,377.00	0.00	INJECTABLE DRUGS	122,647.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,285.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	945.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,040.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	885.00	0.00			
CARDIOLOGY	6,756.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	315,856.50	2,662.00
			TOTAL ACCOMODATIONS	46,176.00	20,568.00
			TOTAL CHARGES	362,032.50	23,230.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:34:06
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NORTHSIDE HOSPITAL, INC
201 HOSPITAL RD
CANTON,GA 30114-2408

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,984,485.41	ADJUSTMENTS	651,037.33
COVERED CHARGES	12,227,237.59	CONTRACTUAL ALLOW	10,025,344.79
NON-COVERD CHARGES	1,757,247.82	TOTAL MEDICAID LIAB	2,201,892.80
		LESS: COB	8,378.66
		LESS: COPAYMENT	2,932.94
		REIMBURSEMENT	2,190,581.20
		ALL OTHER	1,924,762.91
		FEE SCHEDULE-LAB	119,952.03
		INJECTABLE DRUGS	145,866.26

TOTAL NUMBER OF CLAIMS 3,073

NORTHSIDE HOSPITAL, INC
 201 HOSPITAL RD
 CANTON,GA 30114-2408

PROVIDER NUMBER
 000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	317,368.08	526.02	OTHER LAB	128,670.00	0.00
MED/SURG SUPPLY	392,138.50	13,006.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	47.00	EDUCATION & TRAINING	0.00	130.00
RADIOLOGY-DIAGNOSTIC	461,822.00	665.00	OTHER THERAPEUTIC SVC	0.00	644.00
CT SCAN	1,485,108.00	187,489.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	20,764.00	8,581.00	FEE SCHEDULE LAB	1,972,859.06	371,998.94
EKG/ECG	146,620.00	1,780.00	MRI SERVICES	285,046.00	30,767.00
IV THERAPY	408,542.00	63,148.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	765,453.00	77,246.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	35,429.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	65,849.00	4,123.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	167,820.00	6,237.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,902,937.00	89,243.00	SPECIAL SERVICES	0.00	365.00
RECOVERY ROOM	190,304.00	975.00	DRUG-SPECIFIC/HOME IV	0.00	1,630.50
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	951,688.80	644,784.36
RADIOLOGY THERAPEUTIC	264,598.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,108.00	1,492.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	658.00	5,838.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	10,580.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	34.00	1,193.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	81,490.00	0.00
LITHOTRIPSY	57,633.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	421,971.00	89,858.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	32,458.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	246,226.00	3,611.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	178,065.00	140,486.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,998.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	235,580.15	804.00			
			TOTAL ANCILLARY	12,227,237.59	1,757,247.82
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,227,237.59	1,757,247.82

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL, INC
201 HOSPITAL RD
CANTON,GA 30114-2408

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	343,945.50	ADJUSTMENTS	0.00
COVERED CHARGES	226,551.00	CONTRACTUAL ALLOW	109,864.45
NON-COVERD CHARGES	117,394.50	TOTAL MEDICAID LIAB	116,686.55
		LESS: COB	116,649.18
		LESS: COPAYMENT	37.37
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	85

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL, INC
 201 HOSPITAL RD
 CANTON,GA 30114-2408

PROVIDER NUMBER
 000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,785.00	0.00	OTHER LAB	728.00	0.00
MED/SURG SUPPLY	9,282.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,628.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,431.00	8,649.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	47,232.00	4,752.00
EKG/ECG	0.00	598.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,835.00	314.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,816.00	24,367.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,863.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	660.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,898.00	567.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	64,444.00	2,845.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,157.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,562.00	58,282.50
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	1,392.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	19,541.00	17,020.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,403.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,894.00	0.00			
			TOTAL ANCILLARY	226,551.00	117,394.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	226,551.00	117,394.50

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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NORTHSIDE HOSPITAL, INC
201 HOSPITAL RD
CANTON,GA 30114-2408

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	703,833.55	ADJUSTMENTS	1,755.99
COVERED CHARGES	642,415.43	CONTRACTUAL ALLOW	619,815.74
NON-COVERD CHARGES	61,418.12	TOTAL MEDICAID LIAB	22,599.69
		LESS: COB	0.00
		LESS: COPAYMENT	753.00
		REIMBURSEMENT	21,846.69
		TOTAL NUMBER OF CLAIMS	404

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL, INC
 201 HOSPITAL RD
 CANTON,GA 30114-2408

PROVIDER NUMBER
 000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,022.11	0.04	OTHER LAB	2,605.00	0.00
MED/SURG SUPPLY	4,001.00	207.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	46,830.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	49,316.00	13,716.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,400.00	FEE SCHEDULE LAB	127,893.00	18,267.80
EKG/ECG	9,839.00	0.00	MRI SERVICES	0.00	4,643.00
IV THERAPY	10,854.00	4,442.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,793.00	218.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	348,443.00	7,532.00	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	24,673.20	7,754.28
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	68.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,596.00	1,316.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,550.12	1,854.00			
			TOTAL ANCILLARY	642,415.43	61,418.12
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	642,415.43	61,418.12

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL, INC
201 HOSPITAL RD
CANTON,GA 30114-2408

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	34,825.50	ADJUSTMENTS	0.00
COVERED CHARGES	32,972.50	CONTRACTUAL ALLOW	19,845.38
NON-COVERD CHARGES	1,853.00	TOTAL MEDICAID LIAB	13,127.12
		LESS: COB	13,106.12
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	10

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL, INC
 201 HOSPITAL RD
 CANTON,GA 30114-2408

PROVIDER NUMBER
 000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	405.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	322.00	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	6,115.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	373.00	FEE SCHEDULE LAB	6,500.00	577.00
EKG/ECG	299.00	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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,151.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,683.00	903.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,361.00	0.00			
			TOTAL ANCILLARY	32,972.50	1,853.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	32,972.50	1,853.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL, INC
201 HOSPITAL RD
CANTON,GA 30114-2408

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,732,820.05	ADJUSTMENTS	107,227.04
COVERED CHARGES	1,584,731.16	CONTRACTUAL ALLOW	1,346,011.24
NON-COVERD CHARGES	148,088.89	TOTAL MEDICAID LIAB	238,719.92
		LESS: COB	0.00
		LESS: COPAYMENT	166.25
		REIMBURSEMENT	238,553.67
		TOTAL NUMBER OF CLAIMS	45

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL, INC
 201 HOSPITAL RD
 CANTON,GA 30114-2408

PROVIDER NUMBER
 000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,594.98	1,360.00	OTHER LAB	5,418.00	0.00
MED/SURG SUPPLY	111,013.00	3,357.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,267.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	32,593.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,586.00	FEE SCHEDULE LAB	61,141.20	10,531.80
EKG/ECG	4,485.00	598.00	MRI SERVICES	21,481.00	9,286.00
IV THERAPY	61,960.00	2,512.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	229,190.00	44,775.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,237.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	45,868.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,750.00	628.00	SPECIAL SERVICES	0.00	73.00
RECOVERY ROOM	29,982.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	640,764.02	38,788.09
RADIOLOGY THERAPEUTIC	30,400.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,421.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,316.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	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	86,325.00	7,991.00
LITHOTRIPSY	38,422.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,092.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,694.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	18,501.00	1,104.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	59,015.00	22,660.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	28,537.96	0.00			
			TOTAL ANCILLARY	1,584,731.16	148,088.89
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,584,731.16	148,088.89

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL, INC
201 HOSPITAL RD
CANTON,GA 30114-2408

PROVIDER NUMBER
000001108A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF 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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	99,175,900.67	ADJUSTMENTS	8,206,618.44
COVERED CHARGES	96,749,653.46	CONTRACTUAL ALLOW	72,922,656.69
NON-COVERD CHARGES	2,426,247.21	TOTAL MEDICAID LIAB	23,826,996.77
		LESS: COB	96,464.90
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	23,730,531.87

TOTAL NUMBER OF ADMISSIONS 2,301

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	6,344		68	6,227,515.00		943,152.75
ROUTINE NURSERY	1,657		33	1,507,282.50		86,946.40
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	8,001		101	7,734,797.50		1,030,099.15
SPECIAL CARE SERVICES						
CCU	2,516		9	4,363,239.42		50,886.00
ICU	1,624		5	4,594,542.57		14,300.00
NICU	882		0	2,445,280.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	49		0	210,210.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		157	0.00		233,154.50
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	5,071		171	11,613,271.99		298,340.50
TOTAL ACCOMODATIONS	13,072		272	19,348,069.49		1,328,439.65

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,054,884.91	208,792.01	OTHER LAB	638,083.08	1,173.00
MED/SURG SUPPLY	4,586,664.31	93,634.30	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,556,625.69	81,996.00	EDUCATION & TRAINING	55,744.00	132.00
RADIOLOGY-DIAGNOSTIC	2,102,888.10	9,928.00	OTHER THERAPEUTIC SVC	0.00	16,107.62
CT SCAN	4,988,272.80	22,342.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	533,167.00	17,630.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	592,026.00	1,940.00	MRI SERVICES	1,368,572.72	4,467.00
IV THERAPY	1,038,905.21	98,992.00	PROFESSIONAL FEES	0.00	1,786.00
OPERATING ROOM	7,877,701.75	44,888.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,094,515.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,862,798.16	121,882.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,983,981.80	6,303.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,660,060.52	12,168.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,239,240.25	570.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	503,761.00	9,582.00	INJECTABLE DRUGS	468.00	0.00
RADIOLOGY THERAPEUTIC	716,657.00	18,624.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	186,207.00	5,975.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	227,891.50	12,655.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,339,171.21	5,605.00	PATIENT CONVENIENCE	0.00	94.91
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	48,944.00	8,095.00	TRAUMA RESPONSE	0.00	40,254.00
PSYCHIATRIC SERVICES	3,094.00	7,404.00	IMPL DEV CHARGE PATIENTS	2,822,365.69	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	60,854.00
OTHER IMAGING SERVICE	476,022.26	903.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,153,964.58	141,549.72			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	479,552.00	20,984.00			
AUDIOLOGY	130,312.00	0.00			
CARDIOLOGY	2,484,055.40	13,089.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	214,542.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	380,445.03	7,408.00			
			TOTAL ANCILLARY	77,401,583.97	1,097,807.56
			TOTAL ACCOMODATIONS	19,348,069.49	1,328,439.65
			TOTAL CHARGES	96,749,653.46	2,426,247.21

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:34:28
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013204046966	07/13/13 - 07/18/13	07/29/13	0.00	6,862.00	0.00	0.00	0.00
615	2013207067826	07/17/13 - 07/19/13	08/05/13	0.00	6,862.00	0.00	0.00	0.00
615	2013238034502	08/20/13 - 08/21/13	09/02/13	0.00	6,862.00	0.00	0.00	0.00
615	2013242068941	08/23/13 - 08/25/13	09/09/13	0.00	6,862.00	0.00	0.00	0.00
615	2013273034199	09/24/13 - 09/25/13	10/07/13	0.00	6,862.00	0.00	0.00	0.00
615	2013274064830	09/19/13 - 09/26/13	10/07/13	0.00	6,862.00	0.00	0.00	0.00
615	2013316074604	11/05/13 - 11/07/13	11/18/13	0.00	6,862.00	0.00	0.00	0.00
615	2013340002749	11/28/13 - 11/29/13	12/09/13	0.00	6,862.00	0.00	0.00	0.00
616	5214267000019	11/12/13 - 12/04/13	09/29/14	0.00	2,594.00	0.00	0.00	0.00
615	2214289013990	09/06/13 - 10/04/13	10/20/14	0.00	3,364.00	0.00	0.00	0.00
TOTAL				0.00	60,854.00	0.00	0.00	0.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:34:38
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,007,512.80	ADJUSTMENTS	0.00
COVERED CHARGES	1,002,113.80	CONTRACTUAL ALLOW	404,266.07
NON-COVERD CHARGES	5,399.00	TOTAL MEDICAID LIAB	597,847.73
		LESS: COB	597,847.73
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 10

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	19		0	19,266.00		1,919.00
ROUTINE NURSERY	43		0	105,522.00		2,382.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	62		0	124,788.00		4,301.00
SPECIAL CARE SERVICES						
CCU	4		0	6,168.00		0.00
ICU	0		0	0.00		0.00
NICU	84		0	238,056.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	88		0	244,224.00		0.00
TOTAL ACCOMODATIONS	150		0	369,012.00		4,301.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	86,359.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	67,311.55	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	77,889.00	0.00	EDUCATION & TRAINING	1,118.00	0.00
RADIOLOGY-DIAGNOSTIC	10,769.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	469.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	25,817.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	50,621.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	140,218.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,364.00	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	9,648.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	806.00	0.00	INJECTABLE DRUGS	139,591.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,131.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	100.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,636.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,712.00	1,098.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	364.00	0.00			
CARDIOLOGY	2,822.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,356.00	0.00			
			TOTAL ANCILLARY	633,101.80	1,098.00
			TOTAL ACCOMODATIONS	369,012.00	4,301.00
			TOTAL CHARGES	1,002,113.80	5,399.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:34:41
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	30,257,916.45	ADJUSTMENTS	1,163,746.37
COVERED CHARGES	26,027,466.45	CONTRACTUAL ALLOW	21,021,154.94
NON-COVERD CHARGES	4,230,450.00	TOTAL MEDICAID LIAB	5,006,311.51
		LESS: COB	24,128.38
		LESS: COPAYMENT	8,200.56
		REIMBURSEMENT	4,973,982.57
		ALL OTHER	4,358,976.61
		FEE SCHEDULE-LAB	425,283.52
		INJECTABLE DRUGS	189,722.44

TOTAL NUMBER OF CLAIMS 9,860

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	525,204.47	140,641.93	OTHER LAB	479,332.00	2,707.00
MED/SURG SUPPLY	489,543.26	41,927.64	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	752.10	EDUCATION & TRAINING	218.00	0.00
RADIOLOGY-DIAGNOSTIC	1,244,032.00	18,993.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,629,760.00	702,696.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	16,785.00	13,936.00	FEE SCHEDULE LAB	3,870,844.67	750,631.41
EKG/ECG	328,988.00	14,356.00	MRI SERVICES	1,252,801.00	147,452.00
IV THERAPY	788,347.00	357,139.00	PROFESSIONAL FEES	0.00	107.00
OPERATING ROOM	1,307,833.00	195,679.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	204,262.00	1,303.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	134,886.00	58,346.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	646,556.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,922,637.00	117,848.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	538,624.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	205.00	INJECTABLE DRUGS	1,247,747.19	742,081.91
RADIOLOGY THERAPEUTIC	637,062.00	108,330.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	13,219.00	11,400.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	18,682.00	9,246.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	210,761.00	19,619.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	105,360.00	0.00	IMPL DEV CHARGE PATIENTS	72,366.62	178,950.97
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,535.30
OTHER IMAGING SERVICE	1,266,982.00	290,471.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	48,188.00	1,098.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	669,041.00	74,149.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	816,449.00	174,275.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	118,724.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	422,231.24	54,514.74			
			TOTAL ANCILLARY	26,027,466.45	4,230,391.00
			TOTAL ACCOMODATIONS	0.00	59.00
			TOTAL CHARGES	26,027,466.45	4,230,450.00

Report : CLM-0804-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3077	5913240000022	08/08/13 - 08/08/13	09/02/13	0.00	45.00	0.00	0.00	0.00
36	5913288000017	09/23/13 - 09/23/13	10/21/13	0.00	42.00	0.00	0.00	0.00
3690	5913330000044	10/25/13 - 10/25/13	12/02/13	0.00	16.00	0.00	0.00	0.00
948	2014071042878	02/28/14 - 02/28/14	03/17/14	0.00	100.00	0.00	0.00	0.00
36	59140900000646	03/11/14 - 03/11/14	04/07/14	0.00	45.30	0.00	0.00	0.00
948	2014097017895	03/07/14 - 03/07/14	04/14/14	0.00	100.00	0.00	0.00	0.00
948	2014097017895	03/14/14 - 03/14/14	04/14/14	0.00	100.00	0.00	0.00	0.00
948	2014097017895	03/18/14 - 03/18/14	04/14/14	0.00	100.00	0.00	0.00	0.00
948	2014097017895	03/28/14 - 03/28/14	04/14/14	0.00	100.00	0.00	0.00	0.00
3051	5914118000101	03/28/14 - 03/28/14	05/05/14	0.00	12.00	0.00	0.00	0.00
8680	59141190000581	03/25/14 - 03/25/14	05/05/14	0.00	75.00	0.00	0.00	0.00
948	2014126039530	04/08/14 - 04/08/14	05/12/14	0.00	100.00	0.00	0.00	0.00
948	2014126039530	04/15/14 - 04/15/14	05/12/14	0.00	100.00	0.00	0.00	0.00
948	2014157048220	05/06/14 - 05/06/14	06/09/14	0.00	100.00	0.00	0.00	0.00
948	2014157048220	05/09/14 - 05/09/14	06/09/14	0.00	100.00	0.00	0.00	0.00
948	2014157048220	05/13/14 - 05/13/14	06/09/14	0.00	100.00	0.00	0.00	0.00
948	2014157048220	05/16/14 - 05/16/14	06/09/14	0.00	100.00	0.00	0.00	0.00
948	2014157048220	05/20/14 - 05/20/14	06/09/14	0.00	100.00	0.00	0.00	0.00
948	2014157048220	05/23/14 - 05/23/14	06/09/14	0.00	100.00	0.00	0.00	0.00
TOTAL				0.00	1,535.30	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	409,063.33	ADJUSTMENTS	0.00
COVERED CHARGES	348,455.38	CONTRACTUAL ALLOW	215,953.98
NON-COVERD CHARGES	60,607.95	TOTAL MEDICAID LIAB	132,501.40
		LESS: COB	132,416.53
		LESS: COPAYMENT	84.87
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 125

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,538.50	1,800.00	OTHER LAB	10,493.00	0.00
MED/SURG SUPPLY	12,712.32	3,657.76	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,421.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	38,930.00	19,871.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	39,488.20	11,015.22
EKG/ECG	1,644.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,135.00	2,103.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	31,981.00	3,173.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	20,689.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,103.00	722.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	22,914.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	56,733.00	5,069.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,915.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,397.25	458.25
RADIOLOGY THERAPEUTIC	602.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	382.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,216.00	592.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	804.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	4,864.72
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	200.00
OTHER IMAGING SERVICE	32,783.00	5,834.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,472.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,306.00	1,248.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,355.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,441.11	0.00			
			TOTAL ANCILLARY	348,455.38	60,607.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	348,455.38	60,607.95

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR KENNESTONE HOSPITAL	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
677 CHURCH ST NE	000001119A	SERVICE DATES	07/01/13	THROUGH	06/30/14
MARIETTA,GA 30060-1101		ADMISSION DATES	00/00/00	THROUGH	00/00/00

PART III NO COST CENTER OR 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	2014189010920	06/20/14 - 06/20/14	07/14/14	0.00	100.00	0.00	0.00	0.00
948	2014189010920	06/27/14 - 06/27/14	07/14/14	0.00	100.00	0.00	0.00	0.00
TOTAL				0.00	200.00	0.00	0.00	0.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,553,391.14	ADJUSTMENTS	1,662.14
COVERED CHARGES	1,424,542.11	CONTRACTUAL ALLOW	1,381,779.14
NON-COVERD CHARGES	128,849.03	TOTAL MEDICAID LIAB	42,762.97
		LESS: COB	752.03
		LESS: COPAYMENT	1,152.04
		REIMBURSEMENT	40,858.90
		TOTAL NUMBER OF CLAIMS	751

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,451.75	4,013.25	OTHER LAB	42,252.00	0.00
MED/SURG SUPPLY	5,156.86	324.28	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	105,546.00	407.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	115,399.00	19,191.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	259,744.00	29,628.00
EKG/ECG	19,400.00	388.00	MRI SERVICES	4,492.00	12,699.00
IV THERAPY	45,460.00	37,722.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,730.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,981.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,636.00	4,315.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,939.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	699,648.00	1,440.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,048.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,193.50	1,686.50
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	300.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	11,800.00	402.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	56,665.00	16,333.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,424,542.11	128,849.03
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,424,542.11	128,849.03

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:35:18
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,917.51	ADJUSTMENTS	0.00
COVERED CHARGES	4,898.50	CONTRACTUAL ALLOW	3,279.40
NON-COVERD CHARGES	19.01	TOTAL MEDICAID LIAB	1,619.10
		LESS: COB	1,610.10
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	88.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	19.01	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	525.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	475.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	218.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,592.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,898.50	19.01
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,898.50	19.01

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:35:21
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,290,846.00	ADJUSTMENTS	219,147.93
COVERED CHARGES	3,910,000.87	CONTRACTUAL ALLOW	3,468,275.25
NON-COVERD CHARGES	380,845.13	TOTAL MEDICAID LIAB	441,725.62
		LESS: COB	0.00
		LESS: COPAYMENT	1,108.20
		REIMBURSEMENT	440,617.42

TOTAL NUMBER OF CLAIMS 81

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	214,636.86	450.00	OTHER LAB	3,176.00	0.00
MED/SURG SUPPLY	105,048.36	2,312.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	68,341.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	156,976.00	4,449.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	700.00	FEE SCHEDULE LAB	42,243.00	8,771.00
EKG/ECG	8,708.00	1,940.00	MRI SERVICES	0.00	0.00
IV THERAPY	27,652.00	24,499.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	309,378.00	10,879.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,108.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	40,732.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,734.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	37,068.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,022,377.06	279,257.13
RADIOLOGY THERAPEUTIC	1,308,081.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,354.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	395,303.55	34,988.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,503.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,456.00	2,196.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	23,796.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	89,102.00	7,876.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	29,227.04	2,528.00			
			TOTAL ANCILLARY	3,910,000.87	380,845.13
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,910,000.87	380,845.13

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:35:24
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	72,520.41	ADJUSTMENTS	0.00
COVERED CHARGES	71,662.26	CONTRACTUAL ALLOW	23,446.18
NON-COVERD CHARGES	858.15	TOTAL MEDICAID LIAB	48,216.08
		LESS: COB	48,213.08
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0814-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:35:24
 Page: 19

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	645.25	300.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	408.01	554.15	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	583.00	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	68,418.00	4.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	1,518.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	90.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	71,662.26	858.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	71,662.26	858.15

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:35:33
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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 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,538,670.36	ADJUSTMENTS	1,081,171.63
COVERED CHARGES	26,860,570.46	CONTRACTUAL ALLOW	21,176,143.27
NON-COVERD CHARGES	678,099.90	TOTAL MEDICAID LIAB	5,684,427.19
		LESS: COB	24,017.79
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,660,409.40

TOTAL NUMBER OF ADMISSIONS 766

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,829		94	1,711,636.00		162,089.00
ROUTINE NURSERY	145		2	94,657.00		3,611.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,974		96	1,806,293.00		165,700.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	756		7	1,551,187.00		15,889.00
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	16		0	24,416.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	772		7	1,575,603.00		15,889.00
TOTAL ACCOMODATIONS	2,746		103	3,381,896.00		181,589.00

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 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,888,054.87	2,461.00	OTHER LAB	129,759.75	0.00
MED/SURG SUPPLY	1,165,757.20	5,073.40	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,561,918.25	5,991.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	550,271.50	0.00	OTHER THERAPEUTIC SVC	0.00	13,635.00
CT SCAN	963,062.00	248,557.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	212,680.83	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	266,307.25	0.00	MRI SERVICES	248,965.00	0.00
IV THERAPY	10,750.00	1,008.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,176,327.75	8,763.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	316,477.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,138,950.00	4,247.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	198,360.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	90,004.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	839,556.00	3,403.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	292,697.20	0.00	DRUG-SPECIFIC/HOME IV	0.00	56,493.50
LABORATORY PATHOLOGIC	87,233.50	0.00	INJECTABLE DRUGS	6,140,916.45	6,979.25
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	141,838.06	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	48,629.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	137,509.00	11,685.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	9,259.20	186.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	708,077.40	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	211,690.75	0.00			
BLOOD	688.75	0.00			
BLOOD STORAGE & PRO.	89,241.25	83,096.25			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	334,063.00	44,932.00			
AUDIOLOGY	720.00	0.00			
CARDIOLOGY	1,410,484.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	32,640.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	75,785.00	0.00			
			TOTAL ANCILLARY	23,478,674.46	496,510.90
			TOTAL ACCOMODATIONS	3,381,896.00	181,589.00
			TOTAL CHARGES	26,860,570.46	678,099.90

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 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	275,804.05	ADJUSTMENTS	0.00
COVERED CHARGES	274,578.05	CONTRACTUAL ALLOW	160,130.64
NON-COVERD CHARGES	1,226.00	TOTAL MEDICAID LIAB	114,447.41
		LESS: COB	114,447.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 15

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	34		0	31,843.00		755.00
ROUTINE NURSERY	0		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	31,843.00		755.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	5		0	11,465.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	11,465.00		0.00
TOTAL ACCOMODATIONS	39		0	43,308.00		755.00

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 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,967.50	0.00	OTHER LAB	2,054.50	0.00
MED/SURG SUPPLY	8,876.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	36,978.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,675.00	0.00	OTHER THERAPEUTIC SVC	0.00	471.00
CT SCAN	14,627.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,239.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,221.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,622.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	22,919.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	14,031.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	852.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,671.00	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	1,193.50	0.00	INJECTABLE DRUGS	34,888.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,097.75	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	872.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	10,181.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,621.00	0.00			
			TOTAL ANCILLARY	231,270.05	471.00
			TOTAL ACCOMODATIONS	43,308.00	755.00
			TOTAL CHARGES	274,578.05	1,226.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:35:39
Page: 5

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,986,952.55	ADJUSTMENTS	193,391.83
COVERED CHARGES	16,110,245.48	CONTRACTUAL ALLOW	13,385,764.24
NON-COVERD CHARGES	1,876,707.07	TOTAL MEDICAID LIAB	2,724,481.24
		LESS: COB	7,854.93
		LESS: COPAYMENT	4,905.00
		REIMBURSEMENT	2,711,721.31
		ALL OTHER	2,490,744.11
		FEE SCHEDULE-LAB	163,509.41
		INJECTABLE DRUGS	57,467.79

TOTAL NUMBER OF CLAIMS 5,040

FAIRVIEW PARK HOSPITAL
 200 INDUSTRIAL BLVD
 DUBLIN,GA 31021-2981

PROVIDER NUMBER
 000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	383,037.40	235.25	OTHER LAB	117,501.60	0.00
MED/SURG SUPPLY	515,074.70	4,734.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,059,173.00	11,541.25	OTHER THERAPEUTIC SVC	324.00	0.00
CT SCAN	2,664,374.00	314,401.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	94,252.25	6,436.75	FEE SCHEDULE LAB	3,768,062.01	645,410.25
EKG/ECG	222,553.00	15,514.00	MRI SERVICES	317,707.00	33,088.00
IV THERAPY	264,171.00	72,462.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,332,824.51	185,366.80	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	47,129.00	5,278.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	117,549.50	172.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	380,006.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	244,271.35	30,283.65	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,311,338.00	51,710.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	195,023.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	9,704.50
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	828,861.97	190,369.00
RADIOLOGY THERAPEUTIC	3,810.00	1,745.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	24,711.00	5,343.75	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,753.00	5,310.53	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	13,655.00	6,978.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	107,488.00	2,128.40
LITHOTRIPSY	20,357.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	423,299.50	50,747.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	45,254.09	2,930.79			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	182,269.00	35,109.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	172,406.00	183,662.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	141,574.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	109,435.60	6,044.00			
			TOTAL ANCILLARY	16,110,245.48	1,876,707.07
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,110,245.48	1,876,707.07

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 05/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	476,435.30	ADJUSTMENTS	0.00
COVERED CHARGES	362,903.90	CONTRACTUAL ALLOW	188,922.13
NON-COVERD CHARGES	113,531.40	TOTAL MEDICAID LIAB	173,981.77
		LESS: COB	173,948.77
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 107

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 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,669.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	23,999.10	247.40	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	77.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	28,416.25	435.75	OTHER THERAPEUTIC SVC	0.00	324.00
CT SCAN	28,735.00	40,651.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	91,550.00	13,083.25
EKG/ECG	3,425.00	433.00	MRI SERVICES	3,451.00	0.00
IV THERAPY	6,078.00	1,995.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	26,566.75	36,558.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,633.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	768.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,144.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,800.00	3,230.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	58,169.00	1,629.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,565.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,123.50	6,308.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	632.25	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	493.25	870.50	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,333.80	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,500.75	1,335.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	10,602.00	1,835.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,776.00	3,886.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,280.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,825.00	0.00			
			TOTAL ANCILLARY	362,903.90	113,531.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	362,903.90	113,531.40

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:36:00
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FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,064,424.35	ADJUSTMENTS	1,170.68
COVERED CHARGES	1,014,969.75	CONTRACTUAL ALLOW	979,895.37
NON-COVERD CHARGES	49,454.60	TOTAL MEDICAID LIAB	35,074.38
		LESS: COB	0.00
		LESS: COPAYMENT	1,164.04
		REIMBURSEMENT	33,910.34
		TOTAL NUMBER OF CLAIMS	627

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 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,439.00	0.00	OTHER LAB	4,230.50	0.00
MED/SURG SUPPLY	8,929.10	349.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	121,701.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	78,103.00	11,198.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	246,760.75	31,719.25
EKG/ECG	12,011.00	394.00	MRI SERVICES	3,584.00	0.00
IV THERAPY	30,996.00	1,941.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	385.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,414.50	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	426,236.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	59,189.75	2,979.50
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	304.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	232.90	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,871.75	569.25			
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	1,280.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,605.00	0.00			
			TOTAL ANCILLARY	1,014,969.75	49,454.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,014,969.75	49,454.60

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 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	293.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,857.75	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	7,151.75	1,281.50
EKG/ECG	394.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	860.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,144.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	500.50	230.50
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	21,201.70	1,512.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	21,201.70	1,512.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 05/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,884,857.29	ADJUSTMENTS	48,685.77
COVERED CHARGES	2,630,580.80	CONTRACTUAL ALLOW	2,312,620.26
NON-COVERD CHARGES	254,276.49	TOTAL MEDICAID LIAB	317,960.54
		LESS: COB	0.00
		LESS: COPAYMENT	232.80
		REIMBURSEMENT	317,727.74
		TOTAL NUMBER OF CLAIMS	62

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 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	91,458.50	132.75	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	482,147.10	247.40	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	68,644.00	1,553.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,989.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	574.75	FEE SCHEDULE LAB	95,008.75	12,522.14
EKG/ECG	5,512.00	5,079.00	MRI SERVICES	0.00	0.00
IV THERAPY	918.00	426.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	814,608.80	60,416.20	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,392.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	130,748.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,150.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	45,529.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	200,329.05	58,028.50
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	128.00	62.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	472,804.10	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,628.00	1,577.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	164,500.00	113,657.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	15,086.00	0.00			
			TOTAL ANCILLARY	2,630,580.80	254,276.49
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,630,580.80	254,276.49

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	05/01/13	THROUGH	04/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:36:13
 Page: 1

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 12/01/13 THROUGH 11/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,837,203.24	ADJUSTMENTS	168,731.29
COVERED CHARGES	2,762,164.24	CONTRACTUAL ALLOW	2,063,656.73
NON-COVERD CHARGES	75,039.00	TOTAL MEDICAID LIAB	698,507.51
		LESS: COB	5,132.97
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	693,374.54

TOTAL NUMBER OF ADMISSIONS 126

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	451		0	430,705.00		52,952.00
ROUTINE NURSERY	56		0	26,889.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	507		0	457,594.00		52,952.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	36		0	54,792.00		0.00
NICU	3		0	2,835.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	39		0	57,627.00		0.00
TOTAL ACCOMODATIONS	546		0	515,221.00		52,952.00

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 12/01/13 THROUGH 11/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	195,643.00	0.00	OTHER LAB	13,157.00	0.00
MED/SURG SUPPLY	127,955.78	432.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	407,561.60	11,819.00	EDUCATION & TRAINING	4,122.00	1.00
RADIOLOGY-DIAGNOSTIC	27,317.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	155,493.72	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,125.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	11,305.00	0.00	MRI SERVICES	12,007.00	0.00
IV THERAPY	215,471.00	666.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	118,402.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	15,957.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	94,972.50	3,994.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	60,964.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,500.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	186.00	0.00	INJECTABLE DRUGS	574,753.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,632.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	856.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,087.42	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	26,687.57	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	39,572.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,861.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	14,820.00	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	106,534.65	5,175.00			
			TOTAL ANCILLARY	2,246,943.24	22,087.00
			TOTAL ACCOMODATIONS	515,221.00	52,952.00
			TOTAL CHARGES	2,762,164.24	75,039.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 12/01/13 THROUGH 11/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	45,853.14	ADJUSTMENTS	0.00
COVERED CHARGES	45,781.14	CONTRACTUAL ALLOW	26,962.43
NON-COVERD CHARGES	72.00	TOTAL MEDICAID LIAB	18,818.71
		LESS: COB	18,818.71
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	8		0	7,640.00		0.00
ROUTINE NURSERY	3		0	1,299.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	11		0	8,939.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	11		0	8,939.00		0.00

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 12/01/13 THROUGH 11/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,016.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,191.14	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,921.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	193.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,685.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	169.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,926.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,418.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	444.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	895.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	270.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,927.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	107.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	90.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	72.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,590.00	0.00			
			TOTAL ANCILLARY	36,842.14	72.00
			TOTAL ACCOMODATIONS	8,939.00	0.00
			TOTAL CHARGES	45,781.14	72.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

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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 12/01/13 THROUGH 11/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,495,328.21	ADJUSTMENTS	272,022.57
COVERED CHARGES	4,052,149.94	CONTRACTUAL ALLOW	3,285,121.56
NON-COVERD CHARGES	443,178.27	TOTAL MEDICAID LIAB	767,028.38
		LESS: COB	3,357.26
		LESS: COPAYMENT	2,508.14
		REIMBURSEMENT	761,162.98
		ALL OTHER	672,171.70
		FEE SCHEDULE-LAB	83,835.04
		INJECTABLE DRUGS	5,156.24
		TOTAL NUMBER OF CLAIMS	2,736

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 12/01/13 THROUGH 11/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	224,169.00	1,405.00	OTHER LAB	27,114.00	0.00
MED/SURG SUPPLY	119,047.95	144.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1.00	EDUCATION & TRAINING	0.00	1,995.00
RADIOLOGY-DIAGNOSTIC	199,291.00	3,267.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	528,804.92	60,828.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,456.00	4,463.00	FEE SCHEDULE LAB	921,028.56	210,299.37
EKG/ECG	34,090.00	2,261.00	MRI SERVICES	102,321.00	5,230.00
IV THERAPY	91,881.00	21,098.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	240,688.00	20,964.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,981.00	0.00	REHAB THERAPY	0.00	1,085.00
RESPIRATORY SERVICES	41,438.30	13,198.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	859,811.32	28,322.66	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,440.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	175,091.36	21,263.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,215.00	1,408.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	770.92	368.24	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	107.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	17,777.36	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	214,166.00	37,879.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	18,346.00	2,766.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	38,820.00	800.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	30,771.00	799.00			
AMBULATORY SURGERY	472.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	140,158.25	3,227.00			
			TOTAL ANCILLARY	4,052,149.94	443,178.27
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,052,149.94	443,178.27

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 12/01/13 THROUGH 11/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	132,989.20	ADJUSTMENTS	0.00
COVERED CHARGES	101,024.80	CONTRACTUAL ALLOW	50,116.52
NON-COVERD CHARGES	31,964.40	TOTAL MEDICAID LIAB	50,908.28
		LESS: COB	50,866.28
		LESS: COPAYMENT	42.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 84

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 12/01/13 THROUGH 11/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,997.00	1,734.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,077.91	296.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,336.00	213.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,057.00	9,293.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	31,178.52	6,352.40
EKG/ECG	798.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,139.00	1,773.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,536.00	4,360.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	999.00	349.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	30,381.66	2,427.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	720.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,535.00	992.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	559.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,237.00	3,995.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,473.71	180.00			
			TOTAL ANCILLARY	101,024.80	31,964.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	101,024.80	31,964.40

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 12/01/13 THROUGH 11/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	378,076.07	ADJUSTMENTS	1,158.00
COVERED CHARGES	364,476.07	CONTRACTUAL ALLOW	342,226.07
NON-COVERD CHARGES	13,600.00	TOTAL MEDICAID LIAB	22,250.00
		LESS: COB	0.00
		LESS: COPAYMENT	606.00
		REIMBURSEMENT	21,644.00
		TOTAL NUMBER OF CLAIMS	446

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 12/01/13 THROUGH 11/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,688.00	0.00	OTHER LAB	1,952.00	0.00
MED/SURG SUPPLY	3,700.41	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	133.00
RADIOLOGY-DIAGNOSTIC	9,242.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,515.00	1,685.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	92,877.00	4,325.00
EKG/ECG	1,995.00	0.00	MRI SERVICES	2,259.00	0.00
IV THERAPY	5,540.00	98.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,340.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	190,824.66	836.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,640.00	131.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	24,253.00	6,392.00			
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	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,650.00	0.00			
			TOTAL ANCILLARY	364,476.07	13,600.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	364,476.07	13,600.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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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 12/01/13 THROUGH 11/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,310.00	ADJUSTMENTS	0.00
COVERED CHARGES	19,601.00	CONTRACTUAL ALLOW	12,121.73
NON-COVERD CHARGES	4,709.00	TOTAL MEDICAID LIAB	7,479.27
		LESS: COB	7,458.27
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	18

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 12/01/13 THROUGH 11/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	861.00	110.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	280.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	684.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,362.00	896.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	350.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	134.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,083.00	1,046.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	708.00	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,139.00	2,397.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	19,601.00	4,709.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	19,601.00	4,709.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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 12/01/13 THROUGH 11/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	235,694.60	ADJUSTMENTS	24,084.05
COVERED CHARGES	227,968.60	CONTRACTUAL ALLOW	199,049.74
NON-COVERD CHARGES	7,726.00	TOTAL MEDICAID LIAB	28,918.86
		LESS: COB	0.00
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	28,897.86
		TOTAL NUMBER OF CLAIMS	6

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 12/01/13 THROUGH 11/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,960.00	110.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	66,425.14	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	133.00
RADIOLOGY-DIAGNOSTIC	2,573.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,685.00	3,530.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	825.00	FEE SCHEDULE LAB	3,456.00	54.00
EKG/ECG	133.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,603.00	1,447.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	51,770.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,192.00	126.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,981.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,809.00	1,240.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	261.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	107.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	62,524.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	646.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,104.46	0.00			
			TOTAL ANCILLARY	227,968.60	7,726.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	227,968.60	7,726.00

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

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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	12/01/13	THROUGH	11/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

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 05/01/14 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	93,235.00	ADJUSTMENTS	7,382.40
COVERED CHARGES	92,687.25	CONTRACTUAL ALLOW	48,897.12
NON-COVERD CHARGES	547.75	TOTAL MEDICAID LIAB	43,790.13
		LESS: COB	903.44
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	42,886.69

TOTAL NUMBER OF ADMISSIONS 10

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	31		0	12,152.00		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	31		0	12,152.00		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	31		0	12,152.00		0.00

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 05/01/14 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36,992.50	0.00	OTHER LAB	807.50	0.00
MED/SURG SUPPLY	5,662.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	14,339.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,990.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,293.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,135.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,121.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,380.25	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	3,553.25	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	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	491.25	547.75			
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	768.00	0.00			
			TOTAL ANCILLARY	80,535.25	547.75
			TOTAL ACCOMODATIONS	12,152.00	0.00
			TOTAL CHARGES	92,687.25	547.75

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 05/01/14 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 05/01/14 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	274,404.75	ADJUSTMENTS	2,704.04
COVERED CHARGES	245,339.00	CONTRACTUAL ALLOW	139,942.35
NON-COVERD CHARGES	29,065.75	TOTAL MEDICAID LIAB	105,396.65
		LESS: COB	369.42
		LESS: COPAYMENT	348.00
		REIMBURSEMENT	104,679.23
		ALL OTHER	96,038.19
		FEE SCHEDULE-LAB	8,529.88
		INJECTABLE DRUGS	111.16

TOTAL NUMBER OF CLAIMS 323

Report : CLM-0804-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:36:43
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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 05/01/14 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,005.75	0.00	OTHER LAB	2,894.25	0.00
MED/SURG SUPPLY	5,474.50	215.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	11.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,349.50	506.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	42,446.00	14,335.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,582.50	899.75	FEE SCHEDULE LAB	39,868.75	9,785.75
EKG/ECG	2,927.00	324.50	MRI SERVICES	0.00	0.00
IV THERAPY	4,587.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	40.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	67,234.75	378.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	528.50	2,610.75
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	1,760.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	92.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,173.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	26,798.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,576.00	0.00			
			TOTAL ANCILLARY	245,339.00	29,065.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	245,339.00	29,065.75

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 05/01/14 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	962.25	ADJUSTMENTS	0.00
COVERED CHARGES	947.50	CONTRACTUAL ALLOW	579.32
NON-COVERD CHARGES	14.75	TOTAL MEDICAID LIAB	368.18
		LESS: COB	368.18
		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

Report : CLM-0806-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:36:44
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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 05/01/14 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	99.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	299.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	336.25	14.75
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	204.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	947.50	14.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	947.50	14.75

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

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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 05/01/14 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,465.75	ADJUSTMENTS	47.00
COVERED CHARGES	29,077.50	CONTRACTUAL ALLOW	26,577.50
NON-COVERD CHARGES	388.25	TOTAL MEDICAID LIAB	2,500.00
		LESS: COB	0.00
		LESS: COPAYMENT	78.00
		REIMBURSEMENT	2,422.00
		TOTAL NUMBER OF CLAIMS	50

Report : CLM-0808-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 05/01/14 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,517.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	871.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	861.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,169.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,007.25	388.25
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	646.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	17,820.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	185.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	29,077.50	388.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	29,077.50	388.25

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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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	05/01/14	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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	05/01/14	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

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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	05/01/14	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 10/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	213,416.50	ADJUSTMENTS	9,952.17
COVERED CHARGES	197,062.25	CONTRACTUAL ALLOW	126,932.26
NON-COVERD CHARGES	16,354.25	TOTAL MEDICAID LIAB	70,129.99
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	70,129.99

TOTAL NUMBER OF ADMISSIONS 17

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	62		0	24,304.00		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	62		0	24,304.00		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	62		0	24,304.00		0.00

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 10/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	74,915.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	19,472.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	26,480.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,763.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,976.25	13,750.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	562.50	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,561.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,004.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,829.75	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	13,897.75	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	4,120.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	671.25	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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,019.00	2,604.25			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,195.50	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	288.00	0.00			
			TOTAL ANCILLARY	172,758.25	16,354.25
			TOTAL ACCOMODATIONS	24,304.00	0.00
			TOTAL CHARGES	197,062.25	16,354.25

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	10/01/13	THROUGH	04/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	460,550.75	ADJUSTMENTS	23,049.15
COVERED CHARGES	429,620.75	CONTRACTUAL ALLOW	238,316.30
NON-COVERD CHARGES	30,930.00	TOTAL MEDICAID LIAB	191,304.45
		LESS: COB	0.00
		LESS: COPAYMENT	612.00
		REIMBURSEMENT	190,692.45
		ALL OTHER	174,923.19
		FEE SCHEDULE-LAB	15,538.73
		INJECTABLE DRUGS	230.53

TOTAL NUMBER OF CLAIMS 560

Report : CLM-0804-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,693.50	134.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	11,831.25	453.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	33,389.00	603.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	55,960.25	5,367.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,377.00	2,659.50	FEE SCHEDULE LAB	73,091.25	16,870.50
EKG/ECG	6,490.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,441.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,709.75	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	117,181.00	378.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,024.75	2,906.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,368.25	473.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,129.25	961.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	20,728.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	58,470.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,736.50	123.50			
			TOTAL ANCILLARY	429,620.75	30,930.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	429,620.75	30,930.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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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 10/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	587.00	ADJUSTMENTS	0.00
COVERED CHARGES	572.25	CONTRACTUAL ALLOW	572.25
NON-COVERD CHARGES	14.75	TOTAL MEDICAID LIAB	0.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

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 10/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	220.50	14.75
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	313.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	572.25	14.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	572.25	14.75

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

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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 10/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,016.25	ADJUSTMENTS	144.00
COVERED CHARGES	10,841.50	CONTRACTUAL ALLOW	9,691.50
NON-COVERD CHARGES	174.75	TOTAL MEDICAID LIAB	1,150.00
		LESS: COB	0.00
		LESS: COPAYMENT	48.00
		REIMBURSEMENT	1,102.00
		TOTAL NUMBER OF CLAIMS	23

Report : CLM-0808-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,036.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	368.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	382.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,259.75	174.75
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	143.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	120.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,417.25	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	113.50	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	10,841.50	174.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,841.50	174.75

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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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	10/01/13	THROUGH	04/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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	10/01/13	THROUGH	04/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

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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	10/01/13	THROUGH	04/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF 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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	986,831.75	ADJUSTMENTS	0.00
COVERED CHARGES	986,187.45	CONTRACTUAL ALLOW	481,932.22
NON-COVERD CHARGES	644.30	TOTAL MEDICAID LIAB	504,255.23
		LESS: COB	1,064.77
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	503,190.46
		TOTAL NUMBER OF ADMISSIONS	55

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	174		0	97,788.00		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	174		0	97,788.00		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	174		0	97,788.00		0.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
 2460 WASHINTGON ROAD N.E. 000001185A SERVICE DATES 01/01/14 THROUGH 12/31/14
 THOMSON,GA 30824-2199 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	258,367.81	0.00	OTHER LAB	910.00	0.00
MED/SURG SUPPLY	45,925.46	71.30	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	59,425.00	0.00	EDUCATION & TRAINING	81.60	0.00
RADIOLOGY-DIAGNOSTIC	16,774.00	0.00	OTHER THERAPEUTIC SVC	0.00	384.00
CT SCAN	25,146.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	25,484.60	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,060.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	15,310.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	108,340.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,303.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	22,421.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,740.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	45,403.00	189.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	15,277.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,941.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	220,625.98	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,297.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,335.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,232.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	888,399.45	644.30
			TOTAL ACCOMODATIONS	97,788.00	0.00
			TOTAL CHARGES	986,187.45	644.30

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,535,853.66	ADJUSTMENTS	37,449.91
COVERED CHARGES	2,191,189.27	CONTRACTUAL ALLOW	1,518,824.48
NON-COVERD CHARGES	344,664.39	TOTAL MEDICAID LIAB	672,364.79
		LESS: COB	106.50
		LESS: COPAYMENT	1,641.00
		REIMBURSEMENT	670,617.29
		ALL OTHER	626,697.84
		FEE SCHEDULE-LAB	37,116.31
		INJECTABLE DRUGS	6,803.14
		TOTAL NUMBER OF CLAIMS	1,719

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	78,297.75	433.10	OTHER LAB	17,481.00	0.00
MED/SURG SUPPLY	94,027.64	743.99	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	81.60
RADIOLOGY-DIAGNOSTIC	107,102.00	4,398.00	OTHER THERAPEUTIC SVC	0.00	21,152.00
CT SCAN	89,582.00	77,363.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,102.60	FEE SCHEDULE LAB	228,486.80	50,846.00
EKG/ECG	22,472.00	680.00	MRI SERVICES	0.00	0.00
IV THERAPY	106,614.00	6,008.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	191,779.84	79,090.16	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	19,764.00	7,616.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	20,481.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	29,015.00	11,755.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	797,995.00	6,064.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	49,734.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	78,086.25	66,515.94
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	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	816.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	48,967.99	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	69,438.00	1,654.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,268.00	1,602.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	16,160.00	6,464.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	81,001.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	42,436.00	279.00			
			TOTAL ANCILLARY	2,191,189.27	344,664.39
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,191,189.27	344,664.39

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,610.72	ADJUSTMENTS	0.00
COVERED CHARGES	15,589.66	CONTRACTUAL ALLOW	9,768.51
NON-COVERD CHARGES	4,021.06	TOTAL MEDICAID LIAB	5,821.15
		LESS: COB	5,819.65
		LESS: COPAYMENT	1.50
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 10

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
 2460 WASHINTGON ROAD N.E. 000001185A SERVICE DATES 01/01/14 THROUGH 12/31/14
 THOMSON,GA 30824-2199 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,201.03	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	836.38	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,070.00	0.00	OTHER THERAPEUTIC SVC	0.00	237.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,502.00	797.00
EKG/ECG	170.00	170.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,376.00	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	428.00	657.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,721.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	285.25	883.06
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	413.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	15,589.66	4,021.06
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,589.66	4,021.06

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	142,335.40	ADJUSTMENTS	161.82
COVERED CHARGES	129,996.74	CONTRACTUAL ALLOW	119,815.66
NON-COVERD CHARGES	12,338.66	TOTAL MEDICAID LIAB	10,181.08
		LESS: COB	0.00
		LESS: COPAYMENT	384.00
		REIMBURSEMENT	9,797.08
		TOTAL NUMBER OF CLAIMS	182

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
 2460 WASHINTGON ROAD N.E. 000001185A SERVICE DATES 01/01/14 THROUGH 12/31/14
 THOMSON,GA 30824-2199 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,509.82	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,127.48	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,500.00	227.00	OTHER THERAPEUTIC SVC	0.00	3,871.00
CT SCAN	2,944.00	2,331.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,302.00	2,545.00
EKG/ECG	1,190.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,892.00	188.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	642.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	94,176.00	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	5,713.44	3,176.66
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	129,996.74	12,338.66
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	129,996.74	12,338.66

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	567.00	ADJUSTMENTS	0.00
COVERED CHARGES	567.00	CONTRACTUAL ALLOW	216.36
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	350.64
		LESS: COB	350.64
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 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	54.00	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	513.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	567.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	567.00	0.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	35,441.96	ADJUSTMENTS	5,627.41
COVERED CHARGES	34,798.52	CONTRACTUAL ALLOW	24,077.61
NON-COVERD CHARGES	643.44	TOTAL MEDICAID LIAB	10,720.91
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	10,714.91
		TOTAL NUMBER OF CLAIMS	2

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
 2460 WASHINTGON ROAD N.E. 000001185A SERVICE DATES 01/01/14 THROUGH 12/31/14
 THOMSON,GA 30824-2199 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	896.43	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,252.77	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	340.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	58.00	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	7,710.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,419.00	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	818.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	396.82	643.44
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	14,907.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	34,798.52	643.44
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	34,798.52	643.44

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
2460 WASHINTGON ROAD N.E.	000001185A	SERVICE DATES	01/01/14	THROUGH	12/31/14
THOMSON,GA 30824-2199		ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	48,662,624.18	ADJUSTMENTS	3,440,323.56
COVERED CHARGES	48,317,505.51	CONTRACTUAL ALLOW	32,215,759.94
NON-COVERD CHARGES	345,118.67	TOTAL MEDICAID LIAB	16,101,745.57
		LESS: COB	178,449.35
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	15,923,296.22

TOTAL NUMBER OF ADMISSIONS 1,676

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7,033		14	4,490,482.00		43,346.00
ROUTINE NURSERY	1,406		0	923,550.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	8,439		14	5,414,032.00		43,346.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,263		0	1,959,230.00		0.00
NICU	133		0	223,060.00		0.00
PED ICU	60		0	95,058.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,456		0	2,277,348.00		0.00
TOTAL ACCOMODATIONS	9,895		14	7,691,380.00		43,346.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,324,953.14	16.40	OTHER LAB	201,919.71	0.00
MED/SURG SUPPLY	4,068,143.65	36,704.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,014,972.42	31,561.64	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,026,910.43	0.00	OTHER THERAPEUTIC SVC	9,861.88	687.00
CT SCAN	2,664,328.17	45,725.09	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	360,600.10	865.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	273,128.45	0.00	MRI SERVICES	728,307.35	0.00
IV THERAPY	529,777.56	8,244.22	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,634,715.97	9,745.80	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	802,096.90	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,126,179.16	2,771.98	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	197,397.50	0.00	AMBULANCE	0.00	4,171.05
GI SERVICES	9,734.24	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,304,494.31	2,409.94	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	341,367.00	243.80	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	167,077.20	0.00	INJECTABLE DRUGS	1,838,560.06	32.90
RADIOLOGY THERAPEUTIC	134,279.15	4,200.18	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	94,357.17	333.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	97,413.42	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	141,312.00	7,211.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,225.54	27,647.15	TRAUMA RESPONSE	0.00	8,787.95
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,422,862.06	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	400,161.28	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,575,354.00	105,751.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	162,173.36	4,289.57			
AUDIOLOGY	49,585.92	0.00			
CARDIOLOGY	644,505.36	374.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	50,499.76	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	222,871.29	0.00			
			TOTAL ANCILLARY	40,626,125.51	301,772.67
			TOTAL ACCOMODATIONS	7,691,380.00	43,346.00
			TOTAL CHARGES	48,317,505.51	345,118.67

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	912,252.84	ADJUSTMENTS	0.00
COVERED CHARGES	910,307.75	CONTRACTUAL ALLOW	290,516.17
NON-COVERD CHARGES	1,945.09	TOTAL MEDICAID LIAB	619,791.58
		LESS: COB	619,791.58
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 24

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	133		0	85,372.00		1,050.00
ROUTINE NURSERY	83		0	72,900.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	216		0	158,272.00		1,050.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	7		0	11,760.00		0.00
PED ICU	22		0	36,960.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	29		0	48,720.00		0.00
TOTAL ACCOMODATIONS	245		0	206,992.00		1,050.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	227,418.90	0.00	OTHER LAB	2,247.22	0.00
MED/SURG SUPPLY	92,951.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	98,329.13	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,209.77	0.00	OTHER THERAPEUTIC SVC	0.00	606.00
CT SCAN	22,215.70	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,220.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,027.45	0.00	MRI SERVICES	15,561.74	0.00
IV THERAPY	3,226.67	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,536.28	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	23,243.16	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	56,489.72	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,210.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,669.99	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,103.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,569.00	0.00	INJECTABLE DRUGS	59,912.95	0.00
RADIOLOGY THERAPEUTIC	0.00	200.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	605.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	89.09	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	212.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,488.20	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	41,394.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,372.75	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,153.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,940.84	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,007.68	0.00			
			TOTAL ANCILLARY	703,315.75	895.09
			TOTAL ACCOMODATIONS	206,992.00	1,050.00
			TOTAL CHARGES	910,307.75	1,945.09

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:37:16
Page: 5

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,391,975.72	ADJUSTMENTS	1,170,242.24
COVERED CHARGES	22,781,362.28	CONTRACTUAL ALLOW	15,688,675.69
NON-COVERD CHARGES	1,610,613.44	TOTAL MEDICAID LIAB	7,092,686.59
		LESS: COB	38,563.40
		LESS: COPAYMENT	25,436.65
		REIMBURSEMENT	7,028,686.54
		ALL OTHER	6,271,287.49
		FEE SCHEDULE-LAB	395,391.83
		INJECTABLE DRUGS	362,007.22

TOTAL NUMBER OF CLAIMS 17,590

MIDTOWN MEDICAL CENTER
 710 CENTER STREET
 COLUMBUS,GA 31902-1527

PROVIDER NUMBER
 000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	952,359.52	5,922.75	OTHER LAB	122,584.74	0.00
MED/SURG SUPPLY	512,120.30	2,493.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	163.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	991,054.19	8,128.71	OTHER THERAPEUTIC SVC	2,908.64	0.00
CT SCAN	2,529,079.54	245,876.65	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	71,582.00	7,987.34	FEE SCHEDULE LAB	3,242,993.78	546,345.80
EKG/ECG	201,771.75	2,196.50	MRI SERVICES	491,486.15	34,902.27
IV THERAPY	1,169,662.12	3,816.88	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,216,839.12	120,759.03	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	15,373.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	151,728.98	4,523.63	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	58,809.90	164.00	AMBULANCE	0.00	0.00
GI SERVICES	8,429.98	1,746.24	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,356,181.15	29,886.84	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	356,814.80	1,914.90	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,156,092.83	459,519.37
RADIOLOGY THERAPEUTIC	480,229.57	634.54	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	21,013.00	3,491.01	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	345.00	5,489.32	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	13,835.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	695,347.69	9,079.31	TRAUMA RESPONSE	0.00	3,627.95
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	56,110.66	19,032.06
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	928,148.65	60,919.39			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	234,664.00	2,680.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	119,641.33	2,237.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	202,393.70	12,257.00			
AMBULATORY SURGERY	4,194.00	300.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	63,637.34	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	367,764.85	683.45			
			TOTAL ANCILLARY	22,781,362.28	1,610,613.44
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	22,781,362.28	1,610,613.44

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	455,898.37	ADJUSTMENTS	0.00
COVERED CHARGES	328,920.73	CONTRACTUAL ALLOW	112,317.73
NON-COVERD CHARGES	126,977.64	TOTAL MEDICAID LIAB	216,603.00
		LESS: COB	216,451.57
		LESS: COPAYMENT	151.43
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 177

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,836.52	1,158.80	OTHER LAB	1,712.35	0.00
MED/SURG SUPPLY	6,838.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,744.64	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	31,721.60	6,395.15	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	39,675.74	5,419.86
EKG/ECG	1,871.05	0.00	MRI SERVICES	0.00	8,908.83
IV THERAPY	32,952.72	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,473.25	24,611.96	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,284.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	663.43	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,300.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	87,969.87	4,943.38	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,294.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	27,701.70	27,615.75
RADIOLOGY THERAPEUTIC	16,112.20	38,500.00	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	5,433.77	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	17,707.08	9,423.91			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,060.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,048.74	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,570.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,899.92	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,049.65	0.00			
			TOTAL ANCILLARY	328,920.73	126,977.64
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	328,920.73	126,977.64

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,279,829.72	ADJUSTMENTS	2,689.00
COVERED CHARGES	1,209,429.33	CONTRACTUAL ALLOW	1,132,176.20
NON-COVERD CHARGES	70,400.39	TOTAL MEDICAID LIAB	77,253.13
		LESS: COB	17.00
		LESS: COPAYMENT	2,025.00
		REIMBURSEMENT	75,211.13
		TOTAL NUMBER OF CLAIMS	1,381

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	51,283.70	0.00	OTHER LAB	3,758.52	0.00
MED/SURG SUPPLY	12,067.00	64.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	57,188.81	0.00	OTHER THERAPEUTIC SVC	180.96	0.00
CT SCAN	87,667.94	4,810.45	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	329.00	FEE SCHEDULE LAB	186,571.58	22,427.49
EKG/ECG	10,157.95	0.00	MRI SERVICES	10,958.10	2,978.13
IV THERAPY	36,029.88	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,049.70	200.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,421.10	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	681,696.50	465.48	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	121.90	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	30,410.90	35,610.50
RADIOLOGY THERAPEUTIC	6,439.30	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	552.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,238.48	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	18,719.27	2,963.34			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	232.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,235.74	0.00			
			TOTAL ANCILLARY	1,209,429.33	70,400.39
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,209,429.33	70,400.39

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,845.34	ADJUSTMENTS	0.00
COVERED CHARGES	18,189.69	CONTRACTUAL ALLOW	10,508.20
NON-COVERD CHARGES	655.65	TOTAL MEDICAID LIAB	7,681.49
		LESS: COB	7,678.49
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	22

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	623.30	459.65	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	178.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	705.89	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,202.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,489.92	196.00
EKG/ECG	139.15	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	818.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	400.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,112.18	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	520.50	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	18,189.69	655.65
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,189.69	655.65

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:38:07
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,718,342.50	ADJUSTMENTS	372,127.24
COVERED CHARGES	5,541,039.60	CONTRACTUAL ALLOW	4,506,978.52
NON-COVERD CHARGES	177,302.90	TOTAL MEDICAID LIAB	1,034,061.08
		LESS: COB	0.00
		LESS: COPAYMENT	3,798.00
		REIMBURSEMENT	1,030,263.08

TOTAL NUMBER OF CLAIMS 183

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	163,748.24	759.40	OTHER LAB	2,591.11	0.00
MED/SURG SUPPLY	56,829.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	236.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,645.72	0.00	OTHER THERAPEUTIC SVC	6,152.64	0.00
CT SCAN	205,001.65	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	951.00	FEE SCHEDULE LAB	93,195.30	13,875.97
EKG/ECG	2,226.40	0.00	MRI SERVICES	17,533.33	0.00
IV THERAPY	352,851.28	590.21	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	172,086.68	1,360.33	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,600.79	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,992.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,110.16	2,699.87	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	23,635.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,347,960.35	131,677.05
RADIOLOGY THERAPEUTIC	1,596,887.39	22,721.18	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,104.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	49,934.77	48.26	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	93,019.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,500.90	286.63			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	226,603.00	993.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	52,137.91	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,913.85	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	7,882.48	0.00			
			TOTAL ANCILLARY	5,541,039.60	177,302.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,541,039.60	177,302.90

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:38:11
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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

MEDICAL CENTER OF CENTRAL GEORGIA
 777 HEMLOCK ST
 MACON,GA 31201-2102

PROVIDER NUMBER 000001207A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	162,733,809.09	ADJUSTMENTS	5,735,005.02
COVERED CHARGES	159,482,140.79	CONTRACTUAL ALLOW	116,270,400.85
NON-COVERD CHARGES	3,251,668.30	TOTAL MEDICAID LIAB	43,211,739.94
		LESS: COB	434,245.11
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	42,777,494.83

TOTAL NUMBER OF ADMISSIONS 3,657

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	17,300	3	11,651,255.00	1,244,366.00
ROUTINE NURSERY	373	2	97,405.00	607.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	17,673	5	11,748,660.00	1,244,973.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	4,279	0	9,184,992.00	83,815.00
NICU	2,733	0	9,166,751.00	0.00
PED ICU	970	0	2,297,535.00	167,000.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	7,982	0	20,649,278.00	250,815.00
TOTAL ACCOMODATIONS	25,655	5	32,397,938.00	1,495,788.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

MEDICAL CENTER OF CENTRAL GEORGIA
 777 HEMLOCK ST
 MACON,GA 31201-2102

PROVIDER NUMBER
 000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,076,344.71	399,557.74	OTHER LAB	817,905.00	3,065.00
MED/SURG SUPPLY	6,626,099.10	111,011.22	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	16,794,742.45	248,875.00	EDUCATION & TRAINING	148.00	0.00
RADIOLOGY-DIAGNOSTIC	3,853,941.00	14,400.00	OTHER THERAPEUTIC SVC	0.00	16,020.00
CT SCAN	6,041,102.00	143,709.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	628,982.11	7,879.07	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	606,788.00	2,341.00	MRI SERVICES	2,126,054.00	4,532.00
IV THERAPY	1,619,210.00	58,354.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,146,671.00	118,054.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,767,928.00	4,227.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,342,735.00	209,776.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,406,621.00	8,656.00	AMBULANCE	0.00	0.00
GI SERVICES	27,954.00	3,516.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,249,721.01	4,993.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,095,604.00	9,515.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	271,119.00	1,083.00	INJECTABLE DRUGS	8,779,979.24	74,088.07
RADIOLOGY THERAPEUTIC	45,645.00	2,549.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	342,932.05	9,218.08	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	416,421.07	5,735.12	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,054,120.00	119,244.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	150.00	46,495.00	TRAUMA RESPONSE	0.00	15,660.00
PSYCHIATRIC SERVICES	104,063.00	0.00	IMPL DEV CHARGE PATIENTS	6,305,184.88	366.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	477,616.00	2,881.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,785,390.00	15,606.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	657,600.00	31,327.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,386,275.00	1,277.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	124,331.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,104,826.17	61,870.00			
			TOTAL ANCILLARY	127,084,202.79	1,755,880.30
			TOTAL ACCOMODATIONS	32,397,938.00	1,495,788.00
			TOTAL CHARGES	159,482,140.79	3,251,668.30

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

MEDICAL CENTER OF CENTRAL GEORGIA
 777 HEMLOCK ST
 MACON,GA 31201-2102

PROVIDER NUMBER
 000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	438,386.70	ADJUSTMENTS	0.00
COVERED CHARGES	217,598.99	CONTRACTUAL ALLOW	184,983.81
NON-COVERD CHARGES	220,787.71	TOTAL MEDICAID LIAB	32,615.18
		LESS: COB	32,615.18
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	32		0	10,275.00		13,245.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	32		0	10,275.00		13,245.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	14		0	5,050.00		30,300.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	5,050.00		30,300.00
TOTAL ACCOMODATIONS	46		0	15,325.00		43,545.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

MEDICAL CENTER OF CENTRAL GEORGIA
 777 HEMLOCK ST
 MACON,GA 31201-2102

PROVIDER NUMBER
 000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,268.46	39,248.54	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	20,807.00	4,263.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,760.00	22,246.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,231.00	3,179.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,014.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	449.02	360.02	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	620.00	930.00	MRI SERVICES	0.00	6,643.00
IV THERAPY	0.00	160.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	51,588.00	6,440.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	223.00	17,936.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,946.00	1,312.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	2,392.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,902.00	1,365.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	138.00	0.00	INJECTABLE DRUGS	3,821.51	16,131.11
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	360.04	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,515.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	26,715.00	1,350.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	398.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	927.00	3,708.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	21,062.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	25,816.00	42,292.00			
			TOTAL ANCILLARY	202,273.99	177,242.71
			TOTAL ACCOMODATIONS	15,325.00	43,545.00
			TOTAL CHARGES	217,598.99	220,787.71

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:38:47
Page: 5

MEDICAL CENTER OF CENTRAL GEORGIA
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	52,307,312.13	ADJUSTMENTS	3,231,822.77
COVERED CHARGES	47,916,034.04	CONTRACTUAL ALLOW	37,167,462.73
NON-COVERD CHARGES	4,391,278.09	TOTAL MEDICAID LIAB	10,748,571.31
		LESS: COB	45,183.22
		LESS: COPAYMENT	40,283.94
		REIMBURSEMENT	10,663,104.15
		ALL OTHER	8,863,706.34
		FEE SCHEDULE-LAB	1,151,244.22
		INJECTABLE DRUGS	648,153.59

TOTAL NUMBER OF CLAIMS 28,962

MEDICAL CENTER OF CENTRAL GEORGIA
 777 HEMLOCK ST
 MACON,GA 31201-2102

PROVIDER NUMBER
 000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,592,862.65	2,810.33	OTHER LAB	284,311.00	10,927.00
MED/SURG SUPPLY	816,134.00	12,621.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	22.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,028,125.00	63,706.00	OTHER THERAPEUTIC SVC	1,440.00	80.00
CT SCAN	3,734,741.00	315,339.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	36,025.02	20,712.70	FEE SCHEDULE LAB	8,580,068.02	1,700,417.77
EKG/ECG	320,921.00	11,935.00	MRI SERVICES	92,432.00	60,580.00
IV THERAPY	2,083,610.00	231,676.00	PROFESSIONAL FEES	0.00	520.00
OPERATING ROOM	4,733,731.00	634,019.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	351,944.00	1,941.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	286,892.00	18,033.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,234,855.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	90,692.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,687,760.00	29,063.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,507,781.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	46.00	INJECTABLE DRUGS	4,248,435.65	672,407.92
RADIOLOGY THERAPEUTIC	93,884.00	1,200.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	19,683.00	6,284.36	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	50,458.00	3,217.01	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	17,387.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,533,622.70	28,241.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	280.00	0.00	IMPL DEV CHARGE PATIENTS	370,836.00	230,246.00
LITHOTRIPSY	8,092.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	573,299.00	48,257.00			
BLOOD	1,625.00	0.00			
BLOOD STORAGE & PRO.	588,534.00	736.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	763,519.00	45,245.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	728,128.00	69,437.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	133,508.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,337,805.00	154,171.00			
			TOTAL ANCILLARY	47,916,034.04	4,391,278.09
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	47,916,034.04	4,391,278.09

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:40:04
Page: 7

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL CENTER OF CENTRAL GEORGIA
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	327,902.57	ADJUSTMENTS	0.00
COVERED CHARGES	258,967.34	CONTRACTUAL ALLOW	234,760.75
NON-COVERD CHARGES	68,935.23	TOTAL MEDICAID LIAB	24,206.59
		LESS: COB	24,052.83
		LESS: COPAYMENT	153.76
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 77

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL CENTER OF CENTRAL GEORGIA
 777 HEMLOCK ST
 MACON,GA 31201-2102

PROVIDER NUMBER
 000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,018.25	34.84	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,609.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,089.00	0.00	OTHER THERAPEUTIC SVC	80.00	0.00
CT SCAN	13,622.00	6,042.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	29,221.80	5,450.80
EKG/ECG	1,240.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	21,294.00	1,127.00	PROFESSIONAL FEES	0.00	309.00
OPERATING ROOM	30,808.10	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,480.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	111.10	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,743.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,246.00	798.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,318.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	90,007.09	54,666.99
RADIOLOGY THERAPEUTIC	2,084.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,111.00	26.60	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	581.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,663.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	983.00	480.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,450.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,208.00	0.00			
			TOTAL ANCILLARY	258,967.34	68,935.23
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	258,967.34	68,935.23

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

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MEDICAL CENTER OF CENTRAL GEORGIA
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,253,985.70	ADJUSTMENTS	1,805.02
COVERED CHARGES	1,197,416.39	CONTRACTUAL ALLOW	1,138,091.99
NON-COVERD CHARGES	56,569.31	TOTAL MEDICAID LIAB	59,324.40
		LESS: COB	0.00
		LESS: COPAYMENT	2,325.00
		REIMBURSEMENT	56,999.40
		TOTAL NUMBER OF CLAIMS	1,061

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL CENTER OF CENTRAL GEORGIA
 777 HEMLOCK ST
 MACON,GA 31201-2102

PROVIDER NUMBER
 000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	52,913.44	217.83	OTHER LAB	3,121.00	0.00
MED/SURG SUPPLY	1,350.00	628.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	90,953.00	672.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	38,884.00	2,014.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	205,562.00	45,666.00
EKG/ECG	9,920.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	61,208.00	3,399.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	484.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	996.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,476.00	606.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,395.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	701,884.00	566.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,125.95	1,386.48
RADIOLOGY THERAPEUTIC	158.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,947.00	350.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	712.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,327.00	1,064.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,197,416.39	56,569.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,197,416.39	56,569.31

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL CENTER OF CENTRAL GEORGIA
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,349.74	ADJUSTMENTS	0.00
COVERED CHARGES	10,139.74	CONTRACTUAL ALLOW	9,964.74
NON-COVERD CHARGES	210.00	TOTAL MEDICAID LIAB	175.00
		LESS: COB	160.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL CENTER OF CENTRAL GEORGIA
 777 HEMLOCK ST
 MACON,GA 31201-2102

PROVIDER NUMBER
 000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,188.74	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	1,209.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,876.00	210.00
EKG/ECG	155.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,195.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	114.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,322.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	80.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	10,139.74	210.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,139.74	210.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL CENTER OF CENTRAL GEORGIA
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,322,309.91	ADJUSTMENTS	683,553.73
COVERED CHARGES	10,392,155.64	CONTRACTUAL ALLOW	8,818,472.20
NON-COVERD CHARGES	930,154.27	TOTAL MEDICAID LIAB	1,573,683.44
		LESS: COB	5,992.14
		LESS: COPAYMENT	903.90
		REIMBURSEMENT	1,566,787.40
		TOTAL NUMBER OF CLAIMS	265

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL CENTER OF CENTRAL GEORGIA
 777 HEMLOCK ST
 MACON,GA 31201-2102

PROVIDER NUMBER
 000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	504,468.08	768.98	OTHER LAB	84,325.00	15,138.00
MED/SURG SUPPLY	882,335.00	2,376.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	209,225.00	134,812.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	149,958.00	22,416.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,436.02	3,054.17	FEE SCHEDULE LAB	262,477.50	49,115.40
EKG/ECG	31,481.00	6,045.00	MRI SERVICES	15,227.00	8,882.00
IV THERAPY	164,409.00	26,704.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	993,321.01	121,805.02	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	29,150.00	1,500.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	77,272.00	347.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	93,663.00	550.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	73,373.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,989,156.01	84,045.65
RADIOLOGY THERAPEUTIC	11,193.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	93.02	902.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	6,020.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	403.00	778.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,813,322.00	67,998.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	155.00
OTHER IMAGING SERVICE	8,005.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,066.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	54,939.00	239.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	191,731.00	167,229.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,750,127.00	209,274.00			
			TOTAL ANCILLARY	10,392,155.64	930,154.27
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,392,155.64	930,154.27

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL CENTER OF CENTRAL GEORGIA	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
777 HEMLOCK ST	000001207A	SERVICE DATES	10/01/13	THROUGH	09/30/14
MACON,GA 31201-2102		ADMISSION DATES	00/00/00	THROUGH	00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
7330	2214070011988	02/05/14 - 02/05/14	03/17/14	0.00	155.00	0.00	0.00	0.00
TOTAL				0.00	155.00	0.00	0.00	0.00

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL CENTER OF CENTRAL GEORGIA
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	847,070.55	ADJUSTMENTS	193,589.03
COVERED CHARGES	843,366.05	CONTRACTUAL ALLOW	190,510.12
NON-COVERD CHARGES	3,704.50	TOTAL MEDICAID LIAB	652,855.93
		LESS: COB	3,112.16
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	649,743.77

TOTAL NUMBER OF ADMISSIONS 95

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	212		0	67,840.00		0.00
ROUTINE NURSERY	23		0	7,360.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	235		0	75,200.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	77		0	49,205.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	49,205.00		0.00
TOTAL ACCOMODATIONS	312		0	124,405.00		0.00

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	228,096.75	0.00	OTHER LAB	2,484.00	0.00
MED/SURG SUPPLY	65,299.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	179,467.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,967.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	32,438.00	1,600.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,658.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,616.00	0.00	MRI SERVICES	6,016.00	0.00
IV THERAPY	13,370.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	31,602.00	1,149.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	13,303.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	53,181.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,952.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	24,118.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,962.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	257.20	0.00
RADIOLOGY THERAPEUTIC	707.50	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	375.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	205.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	152.00	0.00	IMPL DEV CHARGE PATIENTS	993.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,466.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,917.50	750.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,064.00	0.00			
AUDIOLOGY	550.00	0.00			
CARDIOLOGY	1,944.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,003.00	0.00			
			TOTAL ANCILLARY	718,961.05	3,704.50
			TOTAL ACCOMODATIONS	124,405.00	0.00
			TOTAL CHARGES	843,366.05	3,704.50

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

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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	09/01/13	THROUGH	08/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,066,707.89	ADJUSTMENTS	268,165.92
COVERED CHARGES	1,946,109.44	CONTRACTUAL ALLOW	1,252,764.98
NON-COVERD CHARGES	120,598.45	TOTAL MEDICAID LIAB	693,344.46
		LESS: COB	1,824.82
		LESS: COPAYMENT	3,008.80
		REIMBURSEMENT	688,510.84
		ALL OTHER	547,204.91
		FEE SCHEDULE-LAB	101,457.02
		INJECTABLE DRUGS	39,848.91
		TOTAL NUMBER OF CLAIMS	2,108

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	96,977.23	352.66	OTHER LAB	12,771.00	0.00
MED/SURG SUPPLY	77,997.88	1,193.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	944.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	89,404.85	75.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	182,082.00	11,800.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	17,017.00	10,382.00	FEE SCHEDULE LAB	456,514.60	60,636.10
EKG/ECG	14,412.00	65.00	MRI SERVICES	41,971.50	1,836.00
IV THERAPY	74,075.31	592.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	140,297.30	6,473.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,275.00	50.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	24,012.00	141.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	39,852.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	234,530.25	1,334.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,798.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	223,513.66	15,864.19
RADIOLOGY THERAPEUTIC	6,518.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,867.00	4,140.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,824.00	1,176.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	837.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,236.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,235.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	37,734.00	1,950.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,848.50	250.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	13,194.00	970.00			
AUDIOLOGY	0.00	50.00			
CARDIOLOGY	13,284.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	43,330.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	77,700.36	323.00			
			TOTAL ANCILLARY	1,946,109.44	120,598.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,946,109.44	120,598.45

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,660.58	ADJUSTMENTS	0.00
COVERED CHARGES	10,212.38	CONTRACTUAL ALLOW	3,049.42
NON-COVERD CHARGES	3,448.20	TOTAL MEDICAID LIAB	7,162.96
		LESS: COB	7,153.96
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 17

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	218.95	7.50	OTHER LAB	297.00	0.00
MED/SURG SUPPLY	303.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	269.50	0.00	OTHER THERAPEUTIC SVC	0.00	153.00
CT SCAN	0.00	675.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,699.00	185.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	570.00	50.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	150.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	49.50	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	2,466.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	203.93	452.70
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	45.00	1,750.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	324.00	175.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,100.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	216.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	300.00	0.00			
			TOTAL ANCILLARY	10,212.38	3,448.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,212.38	3,448.20

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

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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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	32,034.91	ADJUSTMENTS	446.80
COVERED CHARGES	31,703.91	CONTRACTUAL ALLOW	25,710.57
NON-COVERD CHARGES	331.00	TOTAL MEDICAID LIAB	5,993.34
		LESS: COB	0.00
		LESS: COPAYMENT	222.00
		REIMBURSEMENT	5,771.34
		TOTAL NUMBER OF CLAIMS	110

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	458.07	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	575.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,011.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	810.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,087.50	293.50
EKG/ECG	198.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	100.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	127.50	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	19,073.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,950.59	37.50
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	312.00	0.00			
			TOTAL ANCILLARY	31,703.91	331.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	31,703.91	331.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	09/01/13	THROUGH	08/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	458,573.24	ADJUSTMENTS	69,800.87
COVERED CHARGES	455,588.84	CONTRACTUAL ALLOW	380,396.19
NON-COVERD CHARGES	2,984.40	TOTAL MEDICAID LIAB	75,192.65
		LESS: COB	0.00
		LESS: COPAYMENT	115.56
		REIMBURSEMENT	75,077.09

TOTAL NUMBER OF CLAIMS 14

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,061.94	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	13,967.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,923.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,533.00	702.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	56.00	0.00	FEE SCHEDULE LAB	10,458.50	1,635.50
EKG/ECG	65.00	0.00	MRI SERVICES	1,683.85	0.00
IV THERAPY	765.00	125.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	21,983.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,340.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,402.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	375.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,561.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	363,229.23	351.90
RADIOLOGY THERAPEUTIC	11,147.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	170.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,880.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,377.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	189.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	829.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	760.97	0.00			
			TOTAL ANCILLARY	455,588.84	2,984.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	455,588.84	2,984.40

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

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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	09/01/13	THROUGH	08/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC
 1900 TEBEAU ST
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER 000001229A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,214,648.44	ADJUSTMENTS	387,361.13
COVERED CHARGES	13,035,539.39	CONTRACTUAL ALLOW	8,285,842.43
NON-COVERD CHARGES	179,109.05	TOTAL MEDICAID LIAB	4,749,696.96
		LESS: COB	31,349.70
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,718,347.26

TOTAL NUMBER OF ADMISSIONS 581

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,969		3	1,320,340.00		94,855.00
ROUTINE NURSERY	103		0	52,270.00		3,090.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,072		3	1,372,610.00		97,945.00
SPECIAL CARE SERVICES						
CCU	490		0	566,990.00		0.00
ICU	167		0	226,285.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	657		0	793,275.00		0.00
TOTAL ACCOMODATIONS	2,729		3	2,165,885.00		97,945.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC
 1900 TEBEAU ST
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER
 000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,686,131.38	5,595.96	OTHER LAB	71,558.00	0.00
MED/SURG SUPPLY	938,106.84	18,064.17	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,345,080.00	2,508.00	EDUCATION & TRAINING	1,138.00	98.00
RADIOLOGY-DIAGNOSTIC	217,503.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	985,435.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	94,631.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	109,935.00	0.00	MRI SERVICES	250,639.00	0.00
IV THERAPY	348,341.00	3,798.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	842,590.00	1,073.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	54,241.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	860,816.00	12,571.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	104,990.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	357,711.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	45,256.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	13,609.92
LABORATORY PATHOLOGIC	37,900.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	95.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,269.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,462.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	223,158.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	385.00	6,240.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	206,248.15	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	84,893.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	91,293.00	11,896.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	116,400.00	0.00			
AUDIOLOGY	5,332.00	0.00			
CARDIOLOGY	546,712.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	23,994.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	211,411.00	5,710.00			
			TOTAL ANCILLARY	10,869,654.39	81,164.05
			TOTAL ACCOMODATIONS	2,165,885.00	97,945.00
			TOTAL CHARGES	13,035,539.39	179,109.05

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC
 1900 TEBEAU ST
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER
 000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	90,294.42	ADJUSTMENTS	0.00
COVERED CHARGES	89,724.42	CONTRACTUAL ALLOW	34,133.73
NON-COVERD CHARGES	570.00	TOTAL MEDICAID LIAB	55,590.69
		LESS: COB	55,590.69
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 7

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	19		0	12,730.00		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	19		0	12,730.00		570.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	2		0	2,710.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	2,710.00		0.00
TOTAL ACCOMODATIONS	21		0	15,440.00		570.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC
 1900 TEBEAU ST
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER
 000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,938.12	0.00	OTHER LAB	436.00	0.00
MED/SURG SUPPLY	5,050.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,109.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	251.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,242.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	189.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	500.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	31,564.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,450.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,546.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	749.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,796.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,026.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,438.00	0.00			
			TOTAL ANCILLARY	74,284.42	0.00
			TOTAL ACCOMODATIONS	15,440.00	570.00
			TOTAL CHARGES	89,724.42	570.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,129,063.86	ADJUSTMENTS	819,174.02
COVERED CHARGES	18,916,553.09	CONTRACTUAL ALLOW	14,717,854.76
NON-COVERD CHARGES	2,212,510.77	TOTAL MEDICAID LIAB	4,198,698.33
		LESS: COB	236.33
		LESS: COPAYMENT	10,258.15
		REIMBURSEMENT	4,188,203.85
		ALL OTHER	2,971,917.22
		FEE SCHEDULE-LAB	404,199.83
		INJECTABLE DRUGS	812,086.80

TOTAL NUMBER OF CLAIMS 9,378

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC
 1900 TEBEAU ST
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER
 000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	835,250.42	504.87	OTHER LAB	439,900.00	99.00
MED/SURG SUPPLY	641,250.80	9,430.20	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	119.00	EDUCATION & TRAINING	111.00	95.00
RADIOLOGY-DIAGNOSTIC	630,447.00	12,308.00	OTHER THERAPEUTIC SVC	138.00	0.00
CT SCAN	2,437,406.00	335,860.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	33,456.00	6,786.04	FEE SCHEDULE LAB	2,394,702.40	365,533.80
EKG/ECG	228,862.00	5,292.00	MRI SERVICES	661,850.00	46,862.00
IV THERAPY	1,027,197.00	83,909.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,426,878.44	188,544.56	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	35,450.00	234.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	125,932.00	12,074.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	3,000.00	AMBULANCE	0.00	0.00
GI SERVICES	615,640.50	25,007.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,735,512.00	14,294.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	231,828.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,054,363.50	831,935.74
RADIOLOGY THERAPEUTIC	15,443.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	9,064.00	1,911.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,536.00	366.06	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	108,294.00	10,834.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	130,149.03	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	360.00
OTHER IMAGING SERVICE	468,790.00	30,354.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	36,904.00	371.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	331,976.00	57,389.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	741,273.00	143,812.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,558.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	511,391.00	25,225.00			
			TOTAL ANCILLARY	18,916,553.09	2,212,510.77
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,916,553.09	2,212,510.77

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014056059390	02/03/14 - 02/03/14	03/03/14	0.00	90.00	0.00	0.00	0.00
948	2014056059390	02/04/14 - 02/04/14	03/03/14	0.00	90.00	0.00	0.00	0.00
948	2014056059390	02/05/14 - 02/05/14	03/03/14	0.00	90.00	0.00	0.00	0.00
948	2014056059390	02/10/14 - 02/10/14	03/03/14	0.00	90.00	0.00	0.00	0.00
TOTAL				0.00	360.00	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:41:42
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	181,129.40	ADJUSTMENTS	0.00
COVERED CHARGES	148,641.54	CONTRACTUAL ALLOW	53,288.32
NON-COVERD CHARGES	32,487.86	TOTAL MEDICAID LIAB	95,353.22
		LESS: COB	95,292.10
		LESS: COPAYMENT	61.12
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 118

SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,131.16	0.00	OTHER LAB	7,283.00	0.00
MED/SURG SUPPLY	6,376.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,495.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,860.00	9,835.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	23,361.00	4,492.00
EKG/ECG	945.00	0.00	MRI SERVICES	4,948.00	3,030.00
IV THERAPY	6,954.00	397.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,090.00	10,043.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,288.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	164.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,590.00	2,706.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	20,165.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,718.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,004.68	765.86
RADIOLOGY THERAPEUTIC	95.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	93.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	122.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,139.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,917.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,902.00	1,219.00			
			TOTAL ANCILLARY	148,641.54	32,487.86
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	148,641.54	32,487.86

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:41:44
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MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	936,950.12	ADJUSTMENTS	1,744.02
COVERED CHARGES	869,770.47	CONTRACTUAL ALLOW	809,243.39
NON-COVERD CHARGES	67,179.65	TOTAL MEDICAID LIAB	60,527.08
		LESS: COB	0.00
		LESS: COPAYMENT	2,136.00
		REIMBURSEMENT	58,391.08
		TOTAL NUMBER OF CLAIMS	1,082

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC
 1900 TEBEAU ST
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER
 000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45,063.29	67.00	OTHER LAB	17,427.00	635.00
MED/SURG SUPPLY	16,862.58	2,981.20	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	72,128.00	1,016.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	97,750.00	36,517.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	382.00	0.00	FEE SCHEDULE LAB	130,102.00	9,574.00
EKG/ECG	11,340.00	378.00	MRI SERVICES	5,974.00	5,621.00
IV THERAPY	58,544.00	1,692.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,284.00	164.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	390,658.00	544.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,846.60	2,791.45
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	347.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,929.00	3,390.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	129.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,133.00	1,680.00			
			TOTAL ANCILLARY	869,770.47	67,179.65
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	869,770.47	67,179.65

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,517.87	ADJUSTMENTS	0.00
COVERED CHARGES	16,803.87	CONTRACTUAL ALLOW	9,360.73
NON-COVERD CHARGES	714.00	TOTAL MEDICAID LIAB	7,443.14
		LESS: COB	7,431.14
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	15

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

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SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC
 1900 TEBEAU ST
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER
 000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	410.17	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	431.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,242.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,875.00	155.00
EKG/ECG	189.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	782.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,484.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22.40	4.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,263.00	555.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,105.00	0.00			
			TOTAL ANCILLARY	16,803.87	714.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,803.87	714.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	990,444.23	ADJUSTMENTS	72,457.58
COVERED CHARGES	907,681.68	CONTRACTUAL ALLOW	735,207.26
NON-COVERD CHARGES	82,762.55	TOTAL MEDICAID LIAB	172,474.42
		LESS: COB	0.00
		LESS: COPAYMENT	90.00
		REIMBURSEMENT	172,384.42
		TOTAL NUMBER OF CLAIMS	31

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
1900 TEBEAU ST	000001229A	SERVICE DATES	01/01/14	THROUGH	12/31/14
WAYCROSS,GA 31501-6357		ADMISSION DATES	00/00/00	THROUGH	00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,463.64	0.00	OTHER LAB	765.00	0.00
MED/SURG SUPPLY	19,812.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	37.00	0.00
RADIOLOGY-DIAGNOSTIC	451.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,016.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,126.00	931.50
EKG/ECG	1,881.00	567.00	MRI SERVICES	0.00	0.00
IV THERAPY	23,623.00	263.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,062.50	3,212.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,652.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,683.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	825.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	737,553.64	70,582.55
RADIOLOGY THERAPEUTIC	371.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	18,865.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	887.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,086.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	52,505.00	7,206.00			
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	2,016.00	0.00			
			TOTAL ANCILLARY	907,681.68	82,762.55
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	907,681.68	82,762.55

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	509,865.01	ADJUSTMENTS	7,888.89
COVERED CHARGES	472,621.86	CONTRACTUAL ALLOW	217,013.66
NON-COVERD CHARGES	37,243.15	TOTAL MEDICAID LIAB	255,608.20
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	255,608.20

TOTAL NUMBER OF ADMISSIONS 40

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	123		0	64,944.00		32,374.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	123		0	64,944.00		32,374.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	123		0	64,944.00		32,374.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	73,462.90	0.00	OTHER LAB	1,387.00	0.00
MED/SURG SUPPLY	24,496.51	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	136,284.55	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,999.40	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	55,597.90	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,561.65	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	537.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,936.10	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,197.55	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,506.35	2,836.95	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,628.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,511.05	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,188.35	0.00	INJECTABLE DRUGS	15,811.23	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	195.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	59.75	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	4,233.85	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,690.10	2,032.20			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,406.20	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	4,986.17	0.00			
			TOTAL ANCILLARY	407,677.86	4,869.15
			TOTAL ACCOMODATIONS	64,944.00	32,374.00
			TOTAL CHARGES	472,621.86	37,243.15

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,056,793.74	ADJUSTMENTS	10,678.21
COVERED CHARGES	1,702,472.46	CONTRACTUAL ALLOW	1,367,731.71
NON-COVERD CHARGES	354,321.28	TOTAL MEDICAID LIAB	334,740.75
		LESS: COB	0.01
		LESS: COPAYMENT	1,242.00
		REIMBURSEMENT	333,498.74
		ALL OTHER	285,735.55
		FEE SCHEDULE-LAB	47,392.80
		INJECTABLE DRUGS	370.39
		TOTAL NUMBER OF CLAIMS	1,574

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,421.35	39,721.15	OTHER LAB	55,679.45	0.00
MED/SURG SUPPLY	58,260.63	1,291.55	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	254.90	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	137,298.80	6,607.45	OTHER THERAPEUTIC SVC	0.00	483.00
CT SCAN	190,799.95	44,350.85	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	691.00	FEE SCHEDULE LAB	581,380.01	169,210.85
EKG/ECG	27,893.40	5,846.20	MRI SERVICES	38,306.00	2,781.20
IV THERAPY	21,336.90	5,031.70	PROFESSIONAL FEES	0.00	90.75
OPERATING ROOM	21,688.10	11,085.73	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,485.90	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,843.35	161.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,787.95	21,686.55	AMBULANCE	0.00	0.00
GI SERVICES	31,392.35	9,428.65	CAST ROOM	0.00	0.00
EMERGENCY ROOM	408,797.88	5,699.55	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,887.38	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,313.35	14,752.30
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	195.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	816.55	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	4,588.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	49,179.80	751.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,115.30	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,022.60	1,152.70			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,564.35	7,064.70			
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	14,017.66	577.95			
			TOTAL ANCILLARY	1,702,472.46	354,321.28
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,702,472.46	354,321.28

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,510.25	ADJUSTMENTS	0.00
COVERED CHARGES	7,643.10	CONTRACTUAL ALLOW	4,100.17
NON-COVERD CHARGES	1,867.15	TOTAL MEDICAID LIAB	3,542.93
		LESS: COB	3,542.93
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 11

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	93.00	58.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	48.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,004.65	1,123.15
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	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	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,147.40	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	685.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	287.75	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,643.10	1,867.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,643.10	1,867.15

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	189,521.68	ADJUSTMENTS	214.76
COVERED CHARGES	175,232.65	CONTRACTUAL ALLOW	159,756.95
NON-COVERD CHARGES	14,289.03	TOTAL MEDICAID LIAB	15,475.70
		LESS: COB	0.00
		LESS: COPAYMENT	501.00
		REIMBURSEMENT	14,974.70
		TOTAL NUMBER OF CLAIMS	278

Report : CLM-0808-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,951.35	4,937.95	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,466.45	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,989.20	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,481.35	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	36,882.10	5,259.22
EKG/ECG	1,532.60	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	668.30	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	61.50	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	105,474.60	300.35	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	1,875.36
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	420.80	1,916.15			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	304.40	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	175,232.65	14,289.03
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	175,232.65	14,289.03

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,544.70	ADJUSTMENTS	0.00
COVERED CHARGES	1,544.70	CONTRACTUAL ALLOW	604.30
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	940.40
		LESS: COB	940.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12.50	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	323.25	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,208.95	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,544.70	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,544.70	0.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF 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 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,209,816.43	ADJUSTMENTS	55,862.27
COVERED CHARGES	3,116,476.43	CONTRACTUAL ALLOW	1,764,985.31
NON-COVERD CHARGES	93,340.00	TOTAL MEDICAID LIAB	1,351,491.12
		LESS: COB	7,705.35
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,343,785.77

TOTAL NUMBER OF ADMISSIONS 268

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	694		0	405,990.00		33,195.00
ROUTINE NURSERY	90		0	45,200.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	784		0	451,190.00		33,195.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	140		0	165,635.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	140		0	165,635.00		0.00
TOTAL ACCOMODATIONS	924		0	616,825.00		33,195.00

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 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	503,092.21	0.00	OTHER LAB	10,794.00	0.00
MED/SURG SUPPLY	391,536.10	40.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	450,549.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	58,957.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	159,986.00	974.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	29,037.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	32,053.00	0.00	MRI SERVICES	69,370.00	0.00
IV THERAPY	353.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	291,970.00	39,746.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	144,116.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	130,486.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,463.45	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	100,096.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	39,618.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	7,936.00	0.00	INJECTABLE DRUGS	5,482.71	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,065.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,167.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	735.94	45.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	246.00
OTHER IMAGING SERVICE	8,737.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	13,684.00	11,642.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,439.00	0.00			
AUDIOLOGY	3,316.00	0.00			
CARDIOLOGY	17,023.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,589.00	7,452.00			
			TOTAL ANCILLARY	2,499,651.43	60,145.00
			TOTAL ACCOMODATIONS	616,825.00	33,195.00
			TOTAL CHARGES	3,116,476.43	93,340.00

Report : CLM-0800-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 04/01/13 THROUGH 03/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
242	2213311013674	10/14/13 - 10/16/13	11/11/13	0.00	246.00	0.00	0.00	0.00
TOTAL				0.00	246.00	0.00	0.00	0.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,575.90	ADJUSTMENTS	0.00
COVERED CHARGES	13,425.90	CONTRACTUAL ALLOW	2,762.27
NON-COVERD CHARGES	150.00	TOTAL MEDICAID LIAB	10,663.63
		LESS: COB	10,663.63
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2		0	1,170.00		150.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2		0	1,170.00		150.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	1,170.00		150.00

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 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	750.15	0.00	OTHER LAB	161.00	0.00
MED/SURG SUPPLY	1,544.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	153.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	132.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,145.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	218.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	152.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	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	12,255.90	0.00
			TOTAL ACCOMODATIONS	1,170.00	150.00
			TOTAL CHARGES	13,425.90	150.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 04/01/13 THROUGH 03/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,962,965.05	ADJUSTMENTS	160,630.74
COVERED CHARGES	3,511,666.50	CONTRACTUAL ALLOW	2,693,646.12
NON-COVERD CHARGES	451,298.55	TOTAL MEDICAID LIAB	818,020.38
		LESS: COB	560.38
		LESS: COPAYMENT	3,576.00
		REIMBURSEMENT	813,884.00
		ALL OTHER	673,285.88
		FEE SCHEDULE-LAB	136,445.51
		INJECTABLE DRUGS	4,152.61
		TOTAL NUMBER OF CLAIMS	4,241

Report : CLM-0804-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	106,984.69	205.30	OTHER LAB	18,849.00	161.00
MED/SURG SUPPLY	175,572.20	5,078.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,254.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	240,160.00	5,861.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	391,622.00	54,503.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	35,461.00	11,850.00	FEE SCHEDULE LAB	1,084,804.80	264,591.20
EKG/ECG	50,448.00	3,787.20	MRI SERVICES	132,914.00	0.00
IV THERAPY	1,823.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	394,884.50	53,437.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,158.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	17,252.00	4,919.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,889.90	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	428,300.00	14,712.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	65,270.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	34,466.41	16,540.35
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,940.00	2,559.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,216.00	2,268.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,124.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,864.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	618.00
OTHER IMAGING SERVICE	97,947.00	1,502.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,638.00	2,902.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,391.00	0.00			
AUDIOLOGY	101.00	0.00			
CARDIOLOGY	16,974.00	961.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	69,133.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	107,479.00	3,589.00			
			TOTAL ANCILLARY	3,511,666.50	451,298.55
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,511,666.50	451,298.55

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 04/01/13 THROUGH 03/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2213107011218	04/10/13 - 04/10/13	04/22/13	0.00	12.00	0.00	0.00	0.00
30	2213112006861	04/06/13 - 04/07/13	04/29/13	0.00	77.00	0.00	0.00	0.00
1	2213120002512	04/23/13 - 04/24/13	05/06/13	0.00	214.00	0.00	0.00	0.00
45	2213120003471	04/21/13 - 04/22/13	05/06/13	0.00	214.00	0.00	0.00	0.00
8502	2213122003245	04/25/13 - 04/25/13	05/06/13	0.00	101.00	0.00	0.00	0.00
TOTAL				0.00	618.00	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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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 04/01/13 THROUGH 03/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	43,689.66	ADJUSTMENTS	0.00
COVERED CHARGES	35,159.66	CONTRACTUAL ALLOW	13,535.57
NON-COVERD CHARGES	8,530.00	TOTAL MEDICAID LIAB	21,624.09
		LESS: COB	21,594.09
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 51

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 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,460.69	0.00	OTHER LAB	644.00	0.00
MED/SURG SUPPLY	1,156.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	651.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,603.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	333.00	4,937.00	FEE SCHEDULE LAB	13,298.00	2,975.00
EKG/ECG	388.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	131.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,952.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	767.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	54.05	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,042.00	196.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,159.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	214.92	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	186.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	364.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	320.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,495.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	261.00	102.00			
			TOTAL ANCILLARY	35,159.66	8,530.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	35,159.66	8,530.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

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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 04/01/13 THROUGH 03/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	160,860.26	ADJUSTMENTS	1,374.04
COVERED CHARGES	153,587.16	CONTRACTUAL ALLOW	134,873.72
NON-COVERD CHARGES	7,273.10	TOTAL MEDICAID LIAB	18,713.44
		LESS: COB	0.00
		LESS: COPAYMENT	681.01
		REIMBURSEMENT	18,032.43
		TOTAL NUMBER OF CLAIMS	351

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 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,139.20	12.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,708.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	73.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,958.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,877.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	30,288.00	5,565.00
EKG/ECG	1,144.00	194.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,694.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	290.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	392.45	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	75,667.00	674.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,036.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,080.51	497.10
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,638.00	258.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	675.00	0.00			
			TOTAL ANCILLARY	153,587.16	7,273.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	153,587.16	7,273.10

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 04/01/13 THROUGH 03/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	471.25	ADJUSTMENTS	0.00
COVERED CHARGES	471.25	CONTRACTUAL ALLOW	263.74
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	207.51
		LESS: COB	204.51
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45.25	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	81.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	345.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	471.25	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	471.25	0.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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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 04/01/13 THROUGH 03/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	65,084.80	ADJUSTMENTS	0.00
COVERED CHARGES	61,423.20	CONTRACTUAL ALLOW	46,124.73
NON-COVERD CHARGES	3,661.60	TOTAL MEDICAID LIAB	15,298.47
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	15,286.47

TOTAL NUMBER OF CLAIMS 3

Report : CLM-0812-0
 Process : CLMJ0800
 Location: CLMP8000

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

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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 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,680.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	33,625.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	353.00	2,641.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	276.00	FEE SCHEDULE LAB	825.00	327.00
EKG/ECG	0.00	194.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,653.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,186.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,845.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	254.70	223.60
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	61,423.20	3,661.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	61,423.20	3,661.60

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

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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 04/01/13 THROUGH 03/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,236.48	ADJUSTMENTS	0.00
COVERED CHARGES	16,818.48	CONTRACTUAL ALLOW	2,206.52
NON-COVERD CHARGES	5,418.00	TOTAL MEDICAID LIAB	14,611.96
		LESS: COB	14,611.96
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

Report : CLM-0814-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	838.03	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	13,783.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	80.00	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	5,418.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	357.20	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,760.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	16,818.48	5,418.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,818.48	5,418.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

MEMORIAL HEALTH UNIV MED CEN, INC
 4700 WATERS AVE
 SAVANNAH,GA 31404-6220

PROVIDER NUMBER 000001273A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	117,798,697.29	ADJUSTMENTS	8,001,434.36
COVERED CHARGES	112,158,740.69	CONTRACTUAL ALLOW	79,359,755.70
NON-COVERD CHARGES	5,639,956.60	TOTAL MEDICAID LIAB	32,798,984.99
		LESS: COB	332,193.89
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	32,466,791.10

TOTAL NUMBER OF ADMISSIONS 3,099

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	12,464		512	10,134,702.00		4,026,447.00
ROUTINE NURSERY	1,256		7	2,192,356.00		3,619.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		1.00
TOTAL ROUTINE	13,720		519	12,327,058.00		4,030,067.00
SPECIAL CARE SERVICES						
CCU	227		0	684,449.00		0.00
ICU	3,124		10	5,974,765.00		142,990.00
NICU	1,141		0	3,744,750.15		11.85
PED ICU	502		0	1,980,892.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	473		0	1,426,691.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		22	0.00		22,880.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	5,467		32	13,811,547.15		165,881.85
TOTAL ACCOMODATIONS	19,187		551	26,138,605.15		4,195,948.85

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

MEMORIAL HEALTH UNIV MED CEN, INC
 4700 WATERS AVE
 SAVANNAH,GA 31404-6220

PROVIDER NUMBER
 000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,662,645.68	173,822.16	OTHER LAB	631,712.00	4,182.00
MED/SURG SUPPLY	6,266,343.90	187,640.24	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,184,801.96	99,988.33	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,556,714.00	8,263.00	OTHER THERAPEUTIC SVC	27,379.00	25,381.00
CT SCAN	5,148,297.00	11,188.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,087,838.19	6,373.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	361,735.00	368.00	MRI SERVICES	1,388,650.00	9,856.00
IV THERAPY	930,293.00	9,333.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,335,728.64	53,723.36	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	980,900.00	33,000.00	REHAB THERAPY	15,132.00	0.00
RESPIRATORY SERVICES	4,411,490.91	20,060.77	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,241,687.00	9,920.00	AMBULANCE	0.00	0.00
GI SERVICES	234,775.00	2,055.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,954,969.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,852,612.00	4,016.00	DRUG-SPECIFIC/HOME IV	0.00	69,353.20
LABORATORY PATHOLOGIC	266,950.13	7,037.00	INJECTABLE DRUGS	3,706,444.48	9,814.80
RADIOLOGY THERAPEUTIC	413,218.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	824,400.70	6,178.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	310,060.40	3,272.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	163,408.00	2,763.00	PATIENT CONVENIENCE	0.00	9.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	26,056.00	4,216.00	TRAUMA RESPONSE	0.00	105,936.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,509,756.03	11,192.21
LITHOTRIPSY	14,683.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	665,249.00	39,140.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	97,165.00	393,584.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	265,714.00	126,899.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,246,101.01	959.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	118,613.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	118,612.51	4,484.18			
			TOTAL ANCILLARY	86,020,135.54	1,444,007.75
			TOTAL ACCOMODATIONS	26,138,605.15	4,195,948.85
			TOTAL CHARGES	112,158,740.69	5,639,956.60

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

MEMORIAL HEALTH UNIV MED CEN, INC
 4700 WATERS AVE
 SAVANNAH,GA 31404-6220

PROVIDER NUMBER
 000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	923,786.76	ADJUSTMENTS	0.00
COVERED CHARGES	873,270.76	CONTRACTUAL ALLOW	364,054.32
NON-COVERD CHARGES	50,516.00	TOTAL MEDICAID LIAB	509,216.44
		LESS: COB	509,216.44
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 32

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	94		10	76,798.00		50,429.00
ROUTINE NURSERY	8		0	23,192.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	102		10	99,990.00		50,429.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	28		0	61,327.00		0.00
NICU	6		0	19,692.00		0.00
PED ICU	8		0	31,568.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	42		0	112,587.00		0.00
TOTAL ACCOMODATIONS	144		10	212,577.00		50,429.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

MEMORIAL HEALTH UNIV MED CEN, INC
 4700 WATERS AVE
 SAVANNAH,GA 31404-6220

PROVIDER NUMBER
 000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	133,416.51	0.00	OTHER LAB	881.00	0.00
MED/SURG SUPPLY	70,022.23	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	64,328.42	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,196.00	0.00	OTHER THERAPEUTIC SVC	0.00	87.00
CT SCAN	35,212.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,073.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	368.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,468.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	101,584.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	36,828.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	54,017.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	47,341.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,409.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,869.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,947.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,076.00	0.00	INJECTABLE DRUGS	10,606.91	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,650.02	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,204.02	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	228.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,499.63	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,573.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,340.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	959.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	597.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	660,693.76	87.00
			TOTAL ACCOMODATIONS	212,577.00	50,429.00
			TOTAL CHARGES	873,270.76	50,516.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:43:17
Page: 5

MEMORIAL HEALTH UNIV MED CEN, INC
4700 WATERS AVE
SAVANNAH,GA 31404-6220

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	41,052,943.41	ADJUSTMENTS	1,217,472.79
COVERED CHARGES	36,435,285.37	CONTRACTUAL ALLOW	30,117,519.09
NON-COVERD CHARGES	4,617,658.04	TOTAL MEDICAID LIAB	6,317,766.28
		LESS: COB	43,128.26
		LESS: COPAYMENT	14,225.38
		REIMBURSEMENT	6,260,412.64
		ALL OTHER	5,460,475.93
		FEE SCHEDULE-LAB	409,602.89
		INJECTABLE DRUGS	390,333.82

TOTAL NUMBER OF CLAIMS 12,685

MEMORIAL HEALTH UNIV MED CEN, INC
 4700 WATERS AVE
 SAVANNAH,GA 31404-6220

PROVIDER NUMBER
 000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,235,278.31	3,593.15	OTHER LAB	716,850.00	3,272.00
MED/SURG SUPPLY	1,836,950.64	23,899.68	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	183.00
RADIOLOGY-DIAGNOSTIC	1,544,275.00	16,412.00	OTHER THERAPEUTIC SVC	6,895.00	16,313.00
CT SCAN	3,947,991.00	558,264.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	203,552.00	88,389.17	FEE SCHEDULE LAB	2,969,236.53	672,621.93
EKG/ECG	249,379.00	17,112.00	MRI SERVICES	1,481,329.00	250,421.00
IV THERAPY	1,170,011.00	128,302.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,032,887.24	766,286.42	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	197,555.00	30,136.00	REHAB THERAPY	0.00	1,404.00
RESPIRATORY SERVICES	153,965.00	1,867.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,064,607.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	303,284.00	40,184.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,764,753.00	208,938.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,332,382.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	12,052.90
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,389,758.41	465,114.27
RADIOLOGY THERAPEUTIC	1,621,055.00	395,920.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	69,352.00	71,565.11	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	61,234.00	19,062.08	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	194.00	26,949.00	PATIENT CONVENIENCE	0.00	3.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	141,405.00	21,740.00	TRAUMA RESPONSE	0.00	4,414.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	542,043.93	2,535.75
LITHOTRIPSY	73,415.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	896,081.00	113,634.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	65,741.00	131,733.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	359,221.00	332,900.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	340,770.00	190,688.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	78,288.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	585,546.31	1,748.08			
			TOTAL ANCILLARY	36,435,285.37	4,617,658.04
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	36,435,285.37	4,617,658.04

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:44:09
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HEALTH UNIV MED CEN, INC
4700 WATERS AVE
SAVANNAH,GA 31404-6220

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	718,117.75	ADJUSTMENTS	0.00
COVERED CHARGES	509,211.10	CONTRACTUAL ALLOW	406,465.11
NON-COVERD CHARGES	208,906.65	TOTAL MEDICAID LIAB	102,745.99
		LESS: COB	102,579.41
		LESS: COPAYMENT	166.58
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 163

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HEALTH UNIV MED CEN, INC
 4700 WATERS AVE
 SAVANNAH,GA 31404-6220

PROVIDER NUMBER
 000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,010.69	128.30	OTHER LAB	4,401.00	0.00
MED/SURG SUPPLY	31,636.24	112.70	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	38.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,612.00	4,113.02	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	76,821.00	26,830.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	8,150.00	FEE SCHEDULE LAB	39,993.44	17,780.05
EKG/ECG	2,199.00	184.00	MRI SERVICES	34,730.00	51,959.00
IV THERAPY	13,421.00	489.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	35,848.00	42,696.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,594.00	989.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,146.00	140.68	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	31,205.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,305.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	47,882.00	1,532.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	24,600.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	48,588.25	14,981.90
RADIOLOGY THERAPEUTIC	4,832.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,588.00	5,273.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	448.00	4,935.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,593.00	412.00	TRAUMA RESPONSE	0.00	4,414.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	13,238.70	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,849.00	1,584.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	581.00	14,955.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,998.00	1,452.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,302.00	5,754.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	8,074.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	18,714.78	4.00			
			TOTAL ANCILLARY	509,211.10	208,906.65
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	509,211.10	208,906.65

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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MEMORIAL HEALTH UNIV MED CEN, INC
4700 WATERS AVE
SAVANNAH,GA 31404-6220

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,008,048.00	ADJUSTMENTS	367.57
COVERED CHARGES	965,953.96	CONTRACTUAL ALLOW	918,293.09
NON-COVERD CHARGES	42,094.04	TOTAL MEDICAID LIAB	47,660.87
		LESS: COB	0.00
		LESS: COPAYMENT	1,125.00
		REIMBURSEMENT	46,535.87
		TOTAL NUMBER OF CLAIMS	852

Report : CLM-0808-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HEALTH UNIV MED CEN, INC
 4700 WATERS AVE
 SAVANNAH,GA 31404-6220

PROVIDER NUMBER
 000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,937.39	0.00	OTHER LAB	5,391.00	0.00
MED/SURG SUPPLY	8,451.66	593.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	57,674.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	32,992.00	11,617.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	462.00	FEE SCHEDULE LAB	88,197.28	12,651.29
EKG/ECG	3,864.00	184.00	MRI SERVICES	9,963.00	0.00
IV THERAPY	28,902.00	3,553.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,683.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,201.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	730.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,280.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	668,446.00	423.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	985.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,873.33	5,815.75
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	691.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	103.00	231.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,003.00	5,873.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,277.30	0.00			
			TOTAL ANCILLARY	965,953.96	42,094.04
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	965,953.96	42,094.04

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HEALTH UNIV MED CEN, INC
4700 WATERS AVE
SAVANNAH,GA 31404-6220

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,712.40	ADJUSTMENTS	0.00
COVERED CHARGES	3,266.40	CONTRACTUAL ALLOW	2,319.30
NON-COVERD CHARGES	446.00	TOTAL MEDICAID LIAB	947.10
		LESS: COB	947.10
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:44:22
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HEALTH UNIV MED CEN, INC
 4700 WATERS AVE
 SAVANNAH,GA 31404-6220

PROVIDER NUMBER
 000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.20	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	851.00	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	2,407.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	446.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,266.40	446.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,266.40	446.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HEALTH UNIV MED CEN, INC
4700 WATERS AVE
SAVANNAH,GA 31404-6220

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,155,359.90	ADJUSTMENTS	219,223.74
COVERED CHARGES	6,396,622.93	CONTRACTUAL ALLOW	5,731,382.86
NON-COVERD CHARGES	758,736.97	TOTAL MEDICAID LIAB	665,240.07
		LESS: COB	0.00
		LESS: COPAYMENT	1,335.00
		REIMBURSEMENT	663,905.07
		TOTAL NUMBER OF CLAIMS	109

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HEALTH UNIV MED CEN, INC
 4700 WATERS AVE
 SAVANNAH,GA 31404-6220

PROVIDER NUMBER
 000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	114,387.60	0.00	OTHER LAB	2,234.00	0.00
MED/SURG SUPPLY	596,867.95	14,655.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	47,076.00	5,284.00	OTHER THERAPEUTIC SVC	0.00	2,615.00
CT SCAN	112,626.00	16,652.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	3,347.00	FEE SCHEDULE LAB	58,829.36	8,565.33
EKG/ECG	3,496.00	1,104.00	MRI SERVICES	26,191.00	2,835.00
IV THERAPY	28,271.00	1,103.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	782,646.10	300,990.92	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	312.00
RESPIRATORY SERVICES	3,183.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	263,700.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,117.00	1,532.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	109,042.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	719.75
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	444,085.05	38,440.45
RADIOLOGY THERAPEUTIC	769,574.00	98,215.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	383.00	383.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	958.02	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,202.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,447.00	412.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,912,106.93	800.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,537.00	6,090.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	555.00	5,130.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	20,120.00	3,236.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	73,729.00	243,153.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,418.94	2.00			
			TOTAL ANCILLARY	6,396,622.93	758,736.97
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,396,622.93	758,736.97

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HEALTH UNIV MED CEN, INC
4700 WATERS AVE
SAVANNAH,GA 31404-6220

PROVIDER NUMBER
000001273A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:44:42
 Page: 1

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	204,435.92	ADJUSTMENTS	0.00
COVERED CHARGES	202,115.92	CONTRACTUAL ALLOW	104,992.55
NON-COVERD CHARGES	2,320.00	TOTAL MEDICAID LIAB	97,123.37
		LESS: COB	4,467.38
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	92,655.99

TOTAL NUMBER OF ADMISSIONS 19

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	67		0	34,840.00		180.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	67		0	34,840.00		180.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	67		0	34,840.00		180.00

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	40,633.50	0.00	OTHER LAB	1,986.00	0.00
MED/SURG SUPPLY	18,406.67	17.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	27,005.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,418.00	0.00	OTHER THERAPEUTIC SVC	0.00	2,123.00
CT SCAN	23,495.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	760.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,302.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,401.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,889.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,917.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,788.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	693.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,612.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,206.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,234.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,364.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,773.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,392.00	0.00			
			TOTAL ANCILLARY	167,275.92	2,140.00
			TOTAL ACCOMODATIONS	34,840.00	180.00
			TOTAL CHARGES	202,115.92	2,320.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	731,491.41	ADJUSTMENTS	11,177.70
COVERED CHARGES	604,139.59	CONTRACTUAL ALLOW	436,356.88
NON-COVERD CHARGES	127,351.82	TOTAL MEDICAID LIAB	167,782.71
		LESS: COB	304.28
		LESS: COPAYMENT	588.00
		REIMBURSEMENT	166,890.43
		ALL OTHER	150,346.63
		FEE SCHEDULE-LAB	13,339.00
		INJECTABLE DRUGS	3,204.80

TOTAL NUMBER OF CLAIMS 690

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,432.22	17,242.00	OTHER LAB	3,051.00	0.00
MED/SURG SUPPLY	19,028.97	453.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	47,216.00	0.00	OTHER THERAPEUTIC SVC	0.00	29,048.00
CT SCAN	85,226.00	26,795.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	103.00	FEE SCHEDULE LAB	111,282.00	25,330.00
EKG/ECG	20,320.00	4,826.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,498.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,829.00	110.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	45,576.00	11,251.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	204,391.00	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	14,219.40	8,965.02
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	170.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,348.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,182.00	1,874.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	10,284.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,256.00	0.00			
			TOTAL ANCILLARY	604,139.59	127,351.82
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	604,139.59	127,351.82

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,970.50	ADJUSTMENTS	0.00
COVERED CHARGES	6,493.00	CONTRACTUAL ALLOW	2,131.78
NON-COVERD CHARGES	2,477.50	TOTAL MEDICAID LIAB	4,361.22
		LESS: COB	4,361.22
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 13

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7.00	67.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	33.00	118.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	169.00	0.00	OTHER THERAPEUTIC SVC	0.00	65.00
CT SCAN	1,213.00	2,200.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	304.00	0.00
EKG/ECG	0.00	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	4,508.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	57.00	27.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,493.00	2,477.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,493.00	2,477.50

Report : CLM-0808-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	72,000.90	ADJUSTMENTS	285.00
COVERED CHARGES	62,060.50	CONTRACTUAL ALLOW	54,410.50
NON-COVERD CHARGES	9,940.40	TOTAL MEDICAID LIAB	7,650.00
		LESS: COB	0.00
		LESS: COPAYMENT	342.00
		REIMBURSEMENT	7,308.00
		TOTAL NUMBER OF CLAIMS	153

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	567.50	1,246.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	527.00	77.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,845.00	0.00	OTHER THERAPEUTIC SVC	0.00	4,390.00
CT SCAN	1,253.00	2,200.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,601.00	1,407.00
EKG/ECG	762.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,338.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	78.00	55.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	45,035.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,797.00	197.50
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	257.00	367.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	62,060.50	9,940.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	62,060.50	9,940.40

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:44:52
 Page: 1

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,023,300.52	ADJUSTMENTS	27,853.45
COVERED CHARGES	1,019,503.52	CONTRACTUAL ALLOW	646,138.75
NON-COVERD CHARGES	3,797.00	TOTAL MEDICAID LIAB	373,364.77
		LESS: COB	5,730.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	367,634.27

TOTAL NUMBER OF ADMISSIONS 66

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	274		0	105,490.00		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	274		0	105,490.00		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	274		0	105,490.00		0.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	310,774.43	0.00	OTHER LAB	2,344.00	0.00
MED/SURG SUPPLY	128,619.44	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	142,090.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,072.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	118,808.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,057.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,322.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,257.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	86,428.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	40,231.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,580.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,043.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	85.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,735.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,092.00	3,712.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,816.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	744.65	0.00			
			TOTAL ANCILLARY	914,013.52	3,797.00
			TOTAL ACCOMODATIONS	105,490.00	0.00
			TOTAL CHARGES	1,019,503.52	3,797.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,056,134.77	ADJUSTMENTS	27,159.40
COVERED CHARGES	1,807,237.92	CONTRACTUAL ALLOW	1,160,432.20
NON-COVERD CHARGES	248,896.85	TOTAL MEDICAID LIAB	646,805.72
		LESS: COB	0.00
		LESS: COPAYMENT	1,503.00
		REIMBURSEMENT	645,302.72
		ALL OTHER	569,546.63
		FEE SCHEDULE-LAB	75,756.09
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	2,733

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	118,002.08	4,005.35	OTHER LAB	40,436.00	0.00
MED/SURG SUPPLY	142,825.39	493.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	172.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	108,303.00	3,142.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	135,002.00	18,825.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	209.00	FEE SCHEDULE LAB	487,372.00	117,992.50
EKG/ECG	10,366.00	1,090.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,064.00	692.00	PROFESSIONAL FEES	0.00	400.00
OPERATING ROOM	432,209.90	71,445.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,175.00	2,493.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	102,677.00	7,599.00	SPECIAL SERVICES	0.00	162.00
RECOVERY ROOM	43,202.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	628.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	217.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	28,605.00	60.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,348.00	5,500.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,035.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,857.00	2,755.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	129,541.55	10,849.00			
			TOTAL ANCILLARY	1,807,237.92	248,511.85
			TOTAL ACCOMODATIONS	0.00	385.00
			TOTAL CHARGES	1,807,237.92	248,896.85

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,747.10	ADJUSTMENTS	0.00
COVERED CHARGES	13,148.10	CONTRACTUAL ALLOW	2,254.13
NON-COVERD CHARGES	1,599.00	TOTAL MEDICAID LIAB	10,893.97
		LESS: COB	10,890.97
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 41

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	191.60	0.00	OTHER LAB	383.00	0.00
MED/SURG SUPPLY	2,500.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	725.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,674.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,141.00	576.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	316.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	120.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,060.00	298.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,489.30	0.00			
			TOTAL ANCILLARY	13,148.10	1,599.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,148.10	1,599.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	40,423.65	ADJUSTMENTS	50.00
COVERED CHARGES	38,941.65	CONTRACTUAL ALLOW	34,635.65
NON-COVERD CHARGES	1,482.00	TOTAL MEDICAID LIAB	4,306.00
		LESS: COB	0.00
		LESS: COPAYMENT	156.00
		REIMBURSEMENT	4,150.00
		TOTAL NUMBER OF CLAIMS	87

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,931.65	190.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	826.00	163.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,798.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,243.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,574.00	485.00
EKG/ECG	109.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	528.00	76.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	24,508.00	507.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	385.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	39.00	61.00			
			TOTAL ANCILLARY	38,941.65	1,482.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	38,941.65	1,482.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:45:03
Page: 10

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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	282.20	ADJUSTMENTS	0.00
COVERED CHARGES	282.20	CONTRACTUAL ALLOW	85.79
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	196.41
		LESS: COB	196.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:45:03
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9.20	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	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	282.20	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	282.20	0.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	95,575.16	ADJUSTMENTS	0.00
COVERED CHARGES	88,083.16	CONTRACTUAL ALLOW	66,027.83
NON-COVERD CHARGES	7,492.00	TOTAL MEDICAID LIAB	22,055.33
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	22,049.33

TOTAL NUMBER OF CLAIMS 5

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,901.41	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,989.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,015.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,797.00	3,150.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	286.00	209.00	FEE SCHEDULE LAB	7,981.00	2,270.00
EKG/ECG	436.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,118.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	341.00	455.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,210.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	787.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL 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	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,904.00	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	21,368.00	480.00			
			TOTAL ANCILLARY	88,083.16	7,492.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	88,083.16	7,492.00

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	233,858.38	ADJUSTMENTS	0.00
COVERED CHARGES	211,075.48	CONTRACTUAL ALLOW	112,950.15
NON-COVERD CHARGES	22,782.90	TOTAL MEDICAID LIAB	98,125.33
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	98,125.33

TOTAL NUMBER OF ADMISSIONS 17

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	70		0	52,500.00		19,280.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	70		0	52,500.00		19,280.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	70		0	52,500.00		19,280.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,832.67	0.00	OTHER LAB	570.29	0.00
MED/SURG SUPPLY	4,519.26	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	36,774.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,056.11	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	25,058.69	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,880.26	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,924.01	0.00	MRI SERVICES	5,047.12	0.00
IV THERAPY	6,873.27	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	25.88	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,315.16	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	9,076.30	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	497.94	0.00	INJECTABLE DRUGS	29,761.44	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	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,376.00	3,502.90			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,918.89	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	68.19	0.00			
			TOTAL ANCILLARY	158,575.48	3,502.90
			TOTAL ACCOMODATIONS	52,500.00	19,280.00
			TOTAL CHARGES	211,075.48	22,782.90

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:45:13
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,128,428.23	ADJUSTMENTS	55,980.71
COVERED CHARGES	948,216.39	CONTRACTUAL ALLOW	492,627.28
NON-COVERD CHARGES	180,211.84	TOTAL MEDICAID LIAB	455,589.11
		LESS: COB	46.11
		LESS: COPAYMENT	840.18
		REIMBURSEMENT	454,702.82
		ALL OTHER	430,941.11
		FEE SCHEDULE-LAB	20,674.89
		INJECTABLE DRUGS	3,086.82

TOTAL NUMBER OF CLAIMS 862

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,894.81	398.74	OTHER LAB	16,942.99	0.00
MED/SURG SUPPLY	25,849.59	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	64,318.05	963.22	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	136,072.77	52,060.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,270.27	5,887.68	FEE SCHEDULE LAB	190,031.73	50,325.79
EKG/ECG	14,981.49	0.00	MRI SERVICES	43,173.72	7,049.00
IV THERAPY	67,685.29	4,757.33	PROFESSIONAL FEES	0.00	1,622.01
OPERATING ROOM	68,659.20	25,301.98	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	155.28	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,572.49	60.03	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	16,582.96	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	162,774.29	1,476.16	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,453.70	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	36,167.26	7,096.39
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	132.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	127.93	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	34,831.79	4,842.23			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	792.00	792.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,279.26	659.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	8,678.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,504.48	204.57			
			TOTAL ANCILLARY	948,216.39	180,211.84
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	948,216.39	180,211.84

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:45:17
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,916.25	ADJUSTMENTS	0.00
COVERED CHARGES	6,437.41	CONTRACTUAL ALLOW	1,474.16
NON-COVERD CHARGES	4,478.84	TOTAL MEDICAID LIAB	4,963.25
		LESS: COB	4,957.25
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 6

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	264.01	13.46	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	106.22	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,085.86	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,279.05	382.77
EKG/ECG	0.00	0.00	MRI SERVICES	2,010.37	2,039.93
IV THERAPY	71.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	1,705.68	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	73.00	73.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	492.52	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	255.85	264.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	703.59	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	95.94	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,437.41	4,478.84
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,437.41	4,478.84

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:45:17
Page: 8

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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	119,975.73	ADJUSTMENTS	482.00
COVERED CHARGES	107,914.50	CONTRACTUAL ALLOW	98,664.50
NON-COVERD CHARGES	12,061.23	TOTAL MEDICAID LIAB	9,250.00
		LESS: COB	0.00
		LESS: COPAYMENT	315.00
		REIMBURSEMENT	8,935.00
		TOTAL NUMBER OF CLAIMS	185

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,057.79	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,048.18	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,390.17	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,107.16	5,932.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,327.01	5,391.75
EKG/ECG	1,294.55	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,133.18	262.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	143.64	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	47,191.18	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,307.73	475.48
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	541.68	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,372.23	0.00			
			TOTAL ANCILLARY	107,914.50	12,061.23
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	107,914.50	12,061.23

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:45:18
Page: 10

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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,764.62	ADJUSTMENTS	0.00
COVERED CHARGES	1,748.42	CONTRACTUAL ALLOW	666.08
NON-COVERD CHARGES	16.20	TOTAL MEDICAID LIAB	1,082.34
		LESS: COB	1,082.34
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 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	426.52	16.20
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	255.85	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,066.05	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,748.42	16.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,748.42	16.20

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	61,350.30	ADJUSTMENTS	14,976.30
COVERED CHARGES	56,589.77	CONTRACTUAL ALLOW	31,924.66
NON-COVERD CHARGES	4,760.53	TOTAL MEDICAID LIAB	24,665.11
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	24,650.11

TOTAL NUMBER OF CLAIMS 5

Report : CLM-0812-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,936.55	26.92	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	11,841.03	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	819.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	875.12	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	8,444.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	644.00
OPERATING ROOM	28,037.83	456.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	3,046.28	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,062.49	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,208.75	587.33
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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	365.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	56,589.77	4,760.53
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	56,589.77	4,760.53

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:45:19
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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:45:25
 Page: 1

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	91,152.00	ADJUSTMENTS	0.00
COVERED CHARGES	89,546.00	CONTRACTUAL ALLOW	32,908.16
NON-COVERD CHARGES	1,606.00	TOTAL MEDICAID LIAB	56,637.84
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	56,637.84

TOTAL NUMBER OF ADMISSIONS 12

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	55		0	30,690.00		1,606.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	55		0	30,690.00		1,606.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	55		0	30,690.00		1,606.00

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,139.00	0.00	OTHER LAB	528.00	0.00
MED/SURG SUPPLY	1,251.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	14,600.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	761.00	0.00	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	0.00	0.00
EKG/ECG	192.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,097.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	326.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	98.00	0.00			
			TOTAL ANCILLARY	58,856.00	0.00
			TOTAL ACCOMODATIONS	30,690.00	1,606.00
			TOTAL CHARGES	89,546.00	1,606.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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Page: 3

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	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:45:26
Page: 4

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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,235,158.83	ADJUSTMENTS	48,679.19
COVERED CHARGES	2,100,560.80	CONTRACTUAL ALLOW	1,583,185.60
NON-COVERD CHARGES	134,598.03	TOTAL MEDICAID LIAB	517,375.20
		LESS: COB	0.00
		LESS: COPAYMENT	2,571.00
		REIMBURSEMENT	514,804.20
		ALL OTHER	453,609.72
		FEE SCHEDULE-LAB	53,780.57
		INJECTABLE DRUGS	7,413.91
		TOTAL NUMBER OF CLAIMS	2,046

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	245,705.80	115.00	OTHER LAB	6,239.00	0.00
MED/SURG SUPPLY	23,391.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	6,321.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	180,784.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	366,537.00	30,368.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	65,369.00	4,411.00	FEE SCHEDULE LAB	543,448.00	70,827.00
EKG/ECG	10,537.00	224.00	MRI SERVICES	36,696.00	0.00
IV THERAPY	92,315.00	3,433.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,342.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	42,973.00	4,152.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	385,183.00	1,488.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	55,346.00	8,949.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,765.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,886.00	622.03	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	64.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	304.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	21,371.00	1,917.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,738.00	1,497.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	10,721.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,910.00	210.00			
			TOTAL ANCILLARY	2,100,560.80	134,598.03
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,100,560.80	134,598.03

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,205.00	ADJUSTMENTS	0.00
COVERED CHARGES	6,660.00	CONTRACTUAL ALLOW	2,795.87
NON-COVERD CHARGES	545.00	TOTAL MEDICAID LIAB	3,864.13
		LESS: COB	3,861.13
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 9

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 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	1,221.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,623.00	545.00
EKG/ECG	56.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	460.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,028.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	272.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,660.00	545.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,660.00	545.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	124,872.00	ADJUSTMENTS	670.00
COVERED CHARGES	117,764.00	CONTRACTUAL ALLOW	108,264.00
NON-COVERD CHARGES	7,108.00	TOTAL MEDICAID LIAB	9,500.00
		LESS: COB	0.00
		LESS: COPAYMENT	327.00
		REIMBURSEMENT	9,173.00
		TOTAL NUMBER OF CLAIMS	190

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	131.00	5.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	859.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,201.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,576.00	1,721.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	29,422.00	4,103.00
EKG/ECG	528.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,427.00	575.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,024.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	59,638.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,060.00	351.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	663.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,235.00	353.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	117,764.00	7,108.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	117,764.00	7,108.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,042.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,895.00	CONTRACTUAL ALLOW	1,026.24
NON-COVERD CHARGES	147.00	TOTAL MEDICAID LIAB	868.76
		LESS: COB	865.76
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 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	529.00	147.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,319.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	47.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,895.00	147.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,895.00	147.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	453,477.00	ADJUSTMENTS	0.00
COVERED CHARGES	450,150.00	CONTRACTUAL ALLOW	394,817.79
NON-COVERD CHARGES	3,327.00	TOTAL MEDICAID LIAB	55,332.21
		LESS: COB	0.00
		LESS: COPAYMENT	234.00
		REIMBURSEMENT	55,098.21

TOTAL NUMBER OF CLAIMS 12

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	295,968.00	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	276.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	33,930.00	2,401.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	116,393.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	274.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,585.00	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	0.00			
			TOTAL ANCILLARY	450,150.00	3,327.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	450,150.00	3,327.00

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	309,939.96	ADJUSTMENTS	7,689.96
COVERED CHARGES	306,874.96	CONTRACTUAL ALLOW	161,935.84
NON-COVERD CHARGES	3,065.00	TOTAL MEDICAID LIAB	144,939.12
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	144,939.12

TOTAL NUMBER OF ADMISSIONS 30

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	153		0	71,145.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	153		0	71,145.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	5		0	4,540.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	5		0	4,540.00		0.00
TOTAL ACCOMODATIONS	158		0	75,685.00		0.00

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,959.91	0.00	OTHER LAB	1,625.00	0.00
MED/SURG SUPPLY	12,583.87	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	57,869.40	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,979.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	42,107.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,021.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,240.00	0.00	MRI SERVICES	14,212.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,678.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	1,305.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	17,975.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,494.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	85.00	0.00	INJECTABLE DRUGS	7,050.78	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	2,229.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,908.00	1,760.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,023.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,150.00	0.00			
			TOTAL ANCILLARY	231,189.96	3,065.00
			TOTAL ACCOMODATIONS	75,685.00	0.00
			TOTAL CHARGES	306,874.96	3,065.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

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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	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:45:39
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	538,843.31	ADJUSTMENTS	1,638.82
COVERED CHARGES	503,598.91	CONTRACTUAL ALLOW	346,695.48
NON-COVERD CHARGES	35,244.40	TOTAL MEDICAID LIAB	156,903.43
		LESS: COB	127.71
		LESS: COPAYMENT	699.00
		REIMBURSEMENT	156,076.72
		ALL OTHER	146,077.49
		FEE SCHEDULE-LAB	9,752.16
		INJECTABLE DRUGS	247.07

TOTAL NUMBER OF CLAIMS 646

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,981.67	48.40	OTHER LAB	3,868.00	0.00
MED/SURG SUPPLY	5,539.89	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	503.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	42,478.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	93,928.00	7,426.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	208.00	0.00	FEE SCHEDULE LAB	109,268.56	6,995.00
EKG/ECG	8,140.00	1,640.00	MRI SERVICES	25,412.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,417.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,563.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	9,280.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	130,245.00	4,915.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	31,012.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	668.79	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	35.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	21,146.00	2,420.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	324.00	352.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,364.00	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	0.00	1,665.00			
			TOTAL ANCILLARY	503,598.91	35,244.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	503,598.91	35,244.40

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,574.83	ADJUSTMENTS	0.00
COVERED CHARGES	9,203.83	CONTRACTUAL ALLOW	6,367.02
NON-COVERD CHARGES	3,371.00	TOTAL MEDICAID LIAB	2,836.81
		LESS: COB	2,833.81
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 8

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	138.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	79.79	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	541.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,468.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,281.00	57.00
EKG/ECG	162.00	0.00	MRI SERVICES	3,966.00	1,846.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,017.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18.54	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,203.83	3,371.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,203.83	3,371.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	60,010.83	ADJUSTMENTS	150.00
COVERED CHARGES	58,272.83	CONTRACTUAL ALLOW	50,372.83
NON-COVERD CHARGES	1,738.00	TOTAL MEDICAID LIAB	7,900.00
		LESS: COB	0.00
		LESS: COPAYMENT	327.00
		REIMBURSEMENT	7,573.00
		TOTAL NUMBER OF CLAIMS	158

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,835.47	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	642.39	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,524.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,328.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,931.00	1,738.00
EKG/ECG	810.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	74.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	40,923.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	204.97	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	58,272.83	1,738.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	58,272.83	1,738.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:45:41
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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	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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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	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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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	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:45:48
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF MURRAY COUNTY
 707 OLD DALTON ELLIJAY RD
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	269,989.23	ADJUSTMENTS	31,883.28
COVERED CHARGES	269,386.18	CONTRACTUAL ALLOW	166,581.24
NON-COVERD CHARGES	603.05	TOTAL MEDICAID LIAB	102,804.94
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	102,804.94

TOTAL NUMBER OF ADMISSIONS 15

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	38		0	34,694.00		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	34,694.00		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	38		0	34,694.00		0.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF MURRAY COUNTY
 707 OLD DALTON ELLIJAY RD
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,355.33	0.00	OTHER LAB	1,424.59	0.00
MED/SURG SUPPLY	13,916.36	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	67,996.02	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,436.43	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,143.27	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,112.56	0.00	MRI SERVICES	7,787.74	0.00
IV THERAPY	30,055.73	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,658.27	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	30,856.10	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,340.94	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,179.13	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,157.06	0.00	INJECTABLE DRUGS	8,219.41	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	47.96	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,398.37	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	629.88	603.05			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,977.03	0.00			
			TOTAL ANCILLARY	234,692.18	603.05
			TOTAL ACCOMODATIONS	34,694.00	0.00
			TOTAL CHARGES	269,386.18	603.05

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF MURRAY COUNTY
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

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HOSPITAL AUTHORITY OF MURRAY COUNTY
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,763,078.52	ADJUSTMENTS	71,767.68
COVERED CHARGES	2,403,989.69	CONTRACTUAL ALLOW	1,981,600.89
NON-COVERD CHARGES	359,088.83	TOTAL MEDICAID LIAB	422,388.80
		LESS: COB	2,262.87
		LESS: COPAYMENT	669.00
		REIMBURSEMENT	419,456.93
		ALL OTHER	371,763.28
		FEE SCHEDULE-LAB	43,786.65
		INJECTABLE DRUGS	3,907.00
		TOTAL NUMBER OF CLAIMS	1,430

HOSPITAL AUTHORITY OF MURRAY COUNTY
 707 OLD DALTON ELLIJAY RD
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	83,053.88	0.00	OTHER LAB	22,513.01	0.00
MED/SURG SUPPLY	46,145.76	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	169,386.63	342.43	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	284,353.44	173,325.69	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	780,139.01	150,426.42
EKG/ECG	46,559.67	259.38	MRI SERVICES	31,483.13	4,994.54
IV THERAPY	239,428.65	6,492.16	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,267.54	4,910.76	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	50,705.20	5,222.80	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,619.56	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	518,222.24	724.57	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,038.44	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	25,108.15	7,954.28
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	1,757.12	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	730.04	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	35,644.55	727.60			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,654.83	1,809.15			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,206.42	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	47,729.54	141.93			
			TOTAL ANCILLARY	2,403,989.69	359,088.83
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,403,989.69	359,088.83

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HOSPITAL AUTHORITY OF MURRAY COUNTY
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,543.21	ADJUSTMENTS	0.00
COVERED CHARGES	16,563.02	CONTRACTUAL ALLOW	5,551.17
NON-COVERD CHARGES	1,980.19	TOTAL MEDICAID LIAB	11,011.85
		LESS: COB	11,011.85
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 17

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HOSPITAL AUTHORITY OF MURRAY COUNTY
 707 OLD DALTON ELLIJAY RD
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	148.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	146.07	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,180.83	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,101.31	1,686.77
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	727.72	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,180.09	293.42	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	79.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	16,563.02	1,980.19
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,563.02	1,980.19

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

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

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HOSPITAL AUTHORITY OF MURRAY COUNTY
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER 000001383A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	313,995.29	ADJUSTMENTS	917.98
COVERED CHARGES	290,930.65	CONTRACTUAL ALLOW	271,016.01
NON-COVERD CHARGES	23,064.64	TOTAL MEDICAID LIAB	19,914.64
		LESS: COB	0.00
		LESS: COPAYMENT	720.00
		REIMBURSEMENT	19,194.64
		TOTAL NUMBER OF CLAIMS	356

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

HOSPITAL AUTHORITY OF MURRAY COUNTY
 707 OLD DALTON ELLIJAY RD
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,786.90	12.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,799.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,348.57	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,003.50	10,909.06	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	77,226.64	8,289.15
EKG/ECG	2,075.04	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	19,262.90	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,580.30	120.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	144,349.67	431.15	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	1,807.91	1,547.07
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	2,844.93	234.42			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,215.44	1,521.04			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	628.95	0.00			
			TOTAL ANCILLARY	290,930.65	23,064.64
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	290,930.65	23,064.64

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

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

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HOSPITAL AUTHORITY OF MURRAY COUNTY
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,219.88	ADJUSTMENTS	0.00
COVERED CHARGES	3,193.14	CONTRACTUAL ALLOW	1,135.01
NON-COVERD CHARGES	26.74	TOTAL MEDICAID LIAB	2,058.13
		LESS: COB	2,058.13
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

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

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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HOSPITAL AUTHORITY OF MURRAY COUNTY
 707 OLD DALTON ELLIJAY RD
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	43.20	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,142.28	26.74
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	114.69	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	892.97	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,193.14	26.74
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,193.14	26.74

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

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

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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOSPITAL AUTHORITY OF MURRAY COUNTY
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOSPITAL AUTHORITY OF MURRAY COUNTY
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 07/15/2015
 Run Time: 01:46:01
 Page: 1

NEWTON MEDICAL CENTER
 5126 HOSPITAL DR NE
 COVINGTON,GA 30014-2566

PROVIDER NUMBER 000001394A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,607,675.45	ADJUSTMENTS	35,503.27
COVERED CHARGES	6,328,492.65	CONTRACTUAL ALLOW	3,717,191.10
NON-COVERD CHARGES	279,182.80	TOTAL MEDICAID LIAB	2,611,301.55
		LESS: COB	11,984.94
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,599,316.61

TOTAL NUMBER OF ADMISSIONS 415

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	831	10	485,569.27	23,849.99
ROUTINE NURSERY	235	0	135,427.86	198,571.64
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,066	10	620,997.13	222,421.63
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	175	0	245,475.79	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	175	0	245,475.79	0.00
TOTAL ACCOMODATIONS	1,241	10	866,472.92	222,421.63

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

NEWTON MEDICAL CENTER
 5126 HOSPITAL DR NE
 COVINGTON,GA 30014-2566

PROVIDER NUMBER
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	920,673.76	0.00	OTHER LAB	49,117.91	0.00
MED/SURG SUPPLY	619,343.34	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	939,822.06	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	95,302.64	0.00	OTHER THERAPEUTIC SVC	252.65	12,632.50
CT SCAN	522,522.28	36,669.27	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	81,423.54	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	39,192.76	0.00	MRI SERVICES	51,548.20	0.00
IV THERAPY	70,188.28	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	471,479.44	3,589.40	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	75,371.58	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	155,356.23	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,530.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	35,604.01	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	265,599.87	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	198,401.06	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	14,591.31	0.00	INJECTABLE DRUGS	205,950.80	0.00
RADIOLOGY THERAPEUTIC	1,730.60	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,933.56	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	18,555.92	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,494.86	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	207,456.20	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	81,291.88	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	133,209.24	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	10,816.10	3,870.00			
AUDIOLOGY	8,878.64	0.00			
CARDIOLOGY	120,189.05	0.00			
AMBULATORY SURGERY	13,098.58	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	10,707.94	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	29,384.94	0.00			
			TOTAL ANCILLARY	5,462,019.73	56,761.17
			TOTAL ACCOMODATIONS	866,472.92	222,421.63
			TOTAL CHARGES	6,328,492.65	279,182.80

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NEWTON MEDICAL CENTER
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
Run Time: 01:46:04
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NEWTON MEDICAL CENTER
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,706,145.19	ADJUSTMENTS	121,170.36
COVERED CHARGES	8,639,975.87	CONTRACTUAL ALLOW	6,942,640.24
NON-COVERD CHARGES	1,066,169.32	TOTAL MEDICAID LIAB	1,697,335.63
		LESS: COB	2,633.03
		LESS: COPAYMENT	4,050.44
		REIMBURSEMENT	1,690,652.16
		ALL OTHER	1,419,559.46
		FEE SCHEDULE-LAB	136,056.02
		INJECTABLE DRUGS	135,036.68

TOTAL NUMBER OF CLAIMS 4,268

NEWTON MEDICAL CENTER
 5126 HOSPITAL DR NE
 COVINGTON,GA 30014-2566

PROVIDER NUMBER
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	315,028.86	1,995.17	OTHER LAB	57,321.90	1,423.80
MED/SURG SUPPLY	375,108.78	4,020.24	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	2,779.60	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	381,127.24	3,318.23	OTHER THERAPEUTIC SVC	1,010.60	12,884.05
CT SCAN	1,472,841.36	92,105.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	50,620.16	27,681.32	FEE SCHEDULE LAB	1,528,377.45	381,214.63
EKG/ECG	72,548.94	2,756.95	MRI SERVICES	261,838.24	23,413.00
IV THERAPY	14,720.91	134,738.66	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	721,380.70	64,019.55	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,042.80	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	52,457.07	268.14	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,084.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	9,673.81	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,645,191.48	24,477.55	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	106,214.95	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	594,212.96	185,880.37
RADIOLOGY THERAPEUTIC	102,949.15	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	205.90	883.30	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	87.03	493.17	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	42,679.02	6,565.64
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	593.40
OTHER IMAGING SERVICE	269,358.03	52,577.40			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	27,776.12	490.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	25,982.47	25,063.70			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	135,502.87	8,129.15			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	148,841.81	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	223,790.76	7,788.30			
			TOTAL ANCILLARY	8,639,975.87	1,065,560.92
			TOTAL ACCOMODATIONS	0.00	608.40
			TOTAL CHARGES	8,639,975.87	1,066,169.32

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 07/15/2015
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NEWTON MEDICAL CENTER
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
672	2014168002452	05/23/14 - 05/23/14	06/23/14	0.00	593.40	0.00	0.00	0.00
TOTAL				0.00	593.40	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NEWTON MEDICAL CENTER
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	113,995.04	ADJUSTMENTS	0.00
COVERED CHARGES	80,949.18	CONTRACTUAL ALLOW	41,647.51
NON-COVERD CHARGES	33,045.86	TOTAL MEDICAID LIAB	39,301.67
		LESS: COB	39,226.67
		LESS: COPAYMENT	75.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 49

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NEWTON MEDICAL CENTER
 5126 HOSPITAL DR NE
 COVINGTON,GA 30014-2566

PROVIDER NUMBER
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,381.11	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,355.94	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	958.01	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,847.60	1,690.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	108.80	FEE SCHEDULE LAB	13,742.57	2,917.54
EKG/ECG	844.86	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	4,848.80	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	21,141.29	11,165.40	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	723.94	9,544.80	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,642.04	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,393.70	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,380.83	25.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	129.80	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,696.80	1,601.70			
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	1,524.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	715.70	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,470.99	1,143.32			
			TOTAL ANCILLARY	80,949.18	33,045.86
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	80,949.18	33,045.86

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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NEWTON MEDICAL CENTER
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,017,298.18	ADJUSTMENTS	1,318.57
COVERED CHARGES	945,972.61	CONTRACTUAL ALLOW	901,715.65
NON-COVERD CHARGES	71,325.57	TOTAL MEDICAID LIAB	44,256.96
		LESS: COB	23.00
		LESS: COPAYMENT	1,569.00
		REIMBURSEMENT	42,664.96
		TOTAL NUMBER OF CLAIMS	792

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

NEWTON MEDICAL CENTER
 5126 HOSPITAL DR NE
 COVINGTON,GA 30014-2566

PROVIDER NUMBER
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,300.57	50.00	OTHER LAB	4,474.40	0.00
MED/SURG SUPPLY	16,484.35	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	58,466.19	392.00	OTHER THERAPEUTIC SVC	0.00	892.55
CT SCAN	134,313.53	14,964.47	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	544.45	FEE SCHEDULE LAB	217,537.57	31,575.01
EKG/ECG	9,359.86	170.30	MRI SERVICES	2,266.60	0.00
IV THERAPY	461.00	13,070.40	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	993.40	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,033.60	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	430,366.91	1,274.96	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18,050.25	2,146.51
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	58.02	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	21,628.29	6,186.90			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	688.14	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,547.95	0.00			
			TOTAL ANCILLARY	945,972.61	71,325.57
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	945,972.61	71,325.57

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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NEWTON MEDICAL CENTER
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,482.13	ADJUSTMENTS	0.00
COVERED CHARGES	11,608.13	CONTRACTUAL ALLOW	9,540.23
NON-COVERD CHARGES	874.00	TOTAL MEDICAID LIAB	2,067.90
		LESS: COB	2,052.90
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NEWTON MEDICAL CENTER
 5126 HOSPITAL DR NE
 COVINGTON,GA 30014-2566

PROVIDER NUMBER
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	530.71	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	235.07	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	518.30	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,121.60	46.80
EKG/ECG	340.60	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	230.50	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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,712.70	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	144.15	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	1,005.00	596.70			
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	11,608.13	874.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,608.13	874.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII

Run Date: 07/15/2015
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NEWTON MEDICAL CENTER
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	310,570.19	ADJUSTMENTS	0.00
COVERED CHARGES	209,369.17	CONTRACTUAL ALLOW	155,385.44
NON-COVERD CHARGES	101,201.02	TOTAL MEDICAID LIAB	53,983.73
		LESS: COB	0.00
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	53,953.73
		TOTAL NUMBER OF CLAIMS	10

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NEWTON MEDICAL CENTER
 5126 HOSPITAL DR NE
 COVINGTON,GA 30014-2566

PROVIDER NUMBER
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,575.72	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,753.02	670.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	386.10	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,812.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	114.70	FEE SCHEDULE LAB	3,058.30	1,227.60
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	1,563.20	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	34,641.30	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	130.60	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,877.70	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,691.90	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,375.10	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	124,720.33	73,880.22
RADIOLOGY THERAPEUTIC	9,664.36	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	21,867.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	14,361.40	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,198.54	0.00			
			TOTAL ANCILLARY	209,369.17	101,201.02
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	209,369.17	101,201.02

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NEWTON MEDICAL CENTER
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE I
 INPATIENT PAID CLAIMS

Run Date: 07/15/2015
 Run Time: 01:46:28
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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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	97,505,311.85	ADJUSTMENTS	8,283,198.52
COVERED CHARGES	92,577,894.44	CONTRACTUAL ALLOW	68,771,706.37
NON-COVERD CHARGES	4,927,417.41	TOTAL MEDICAID LIAB	23,806,188.07
		LESS: COB	320,075.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	23,486,112.39

TOTAL NUMBER OF ADMISSIONS 4,190

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	8,073		0	8,052,741.00		748,445.00
ROUTINE NURSERY	6,927		256	9,008,080.00		2,805,015.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	15,000		256	17,060,821.00		3,553,460.00
SPECIAL CARE SERVICES						
CCU	20		0	72,635.00		0.00
ICU	2,290		0	7,861,926.00		0.00
NICU	575		0	3,042,571.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,885		0	10,977,132.00		0.00
TOTAL ACCOMODATIONS	17,885		256	28,037,953.00		3,553,460.00

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,500,415.08	147,509.75	OTHER LAB	326,716.00	0.00
MED/SURG SUPPLY	3,485,007.97	88,477.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,209,054.56	36,311.51	EDUCATION & TRAINING	9,166.00	340.00
RADIOLOGY-DIAGNOSTIC	959,275.00	0.00	OTHER THERAPEUTIC SVC	0.00	24,725.00
CT SCAN	1,432,426.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	507,139.00	268.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	182,649.00	0.00	MRI SERVICES	639,882.00	0.00
IV THERAPY	206,134.00	22,816.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,998,392.50	148,900.00	DURABLE MED. EQUIP.	0.00	6,276.00
LABOR/DELIVERY ROOM	6,040,678.50	5,378.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,936,702.01	3,201.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	843,893.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,067,121.00	29,729.00	SPECIAL SERVICES	0.00	14,966.00
RECOVERY ROOM	1,072,914.00	164.00	DRUG-SPECIFIC/HOME IV	0.00	55,841.15
LABORATORY PATHOLOGIC	1,173,461.00	28,728.00	INJECTABLE DRUGS	16,258,870.32	18,945.00
RADIOLOGY THERAPEUTIC	75,881.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	423,823.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	101,662.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	222,638.00	12,696.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	204.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,448.00	0.00	IMPL DEV CHARGE PATIENTS	508,380.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	8,419.00
OTHER IMAGING SERVICE	597,228.00	36,330.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,189,367.00	663,546.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	142,482.00	16,571.00			
AUDIOLOGY	450,503.00	0.00			
CARDIOLOGY	888,001.00	3,724.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	56,555.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	31,872.00	96.00			
			TOTAL ANCILLARY	64,539,941.44	1,373,957.41
			TOTAL ACCOMODATIONS	28,037,953.00	3,553,460.00
			TOTAL CHARGES	92,577,894.44	4,927,417.41

Report : CLM-0800-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

Run Date: 07/15/2015
Run Time: 01:46:28
Page: 3

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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015163039920	12/18/13 - 12/28/13	06/15/15	0.00	8,419.00	0.00	0.00	0.00
TOTAL				0.00	8,419.00	0.00	0.00	0.00

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,621,480.50	ADJUSTMENTS	0.00
COVERED CHARGES	5,323,618.50	CONTRACTUAL ALLOW	2,750,626.84
NON-COVERD CHARGES	297,862.00	TOTAL MEDICAID LIAB	2,572,991.66
		LESS: COB	2,572,991.66
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 122

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	324		0	323,676.00		24,517.00
ROUTINE NURSERY	326		0	785,566.00		234,522.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	650		0	1,109,242.00		259,039.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	82		0	262,761.00		0.00
NICU	186		0	980,778.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	268		0	1,243,539.00		0.00
TOTAL ACCOMODATIONS	918		0	2,352,781.00		259,039.00

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	331,996.00	0.00	OTHER LAB	46,894.00	0.00
MED/SURG SUPPLY	219,812.00	37.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	386,681.00	0.00	EDUCATION & TRAINING	340.00	0.00
RADIOLOGY-DIAGNOSTIC	81,391.00	0.00	OTHER THERAPEUTIC SVC	1,022.00	1,314.00
CT SCAN	12,282.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,509.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,196.00	0.00	MRI SERVICES	12,195.00	0.00
IV THERAPY	4,234.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	202,107.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	420,457.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	332,184.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	41,889.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,625.00	0.00	SPECIAL SERVICES	0.00	37,472.00
RECOVERY ROOM	44,211.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	22,984.00	0.00	INJECTABLE DRUGS	553,838.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	26,791.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,427.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	33,790.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	34,303.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	72,849.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	19,083.00	0.00			
CARDIOLOGY	29,903.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,478.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,366.00	0.00			
			TOTAL ANCILLARY	2,970,837.50	38,823.00
			TOTAL ACCOMODATIONS	2,352,781.00	259,039.00
			TOTAL CHARGES	5,323,618.50	297,862.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
Run Time: 01:46:44
Page: 6

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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	38,503,778.88	ADJUSTMENTS	1,834,960.57
COVERED CHARGES	33,889,550.17	CONTRACTUAL ALLOW	27,053,611.07
NON-COVERD CHARGES	4,614,228.71	TOTAL MEDICAID LIAB	6,835,939.10
		LESS: COB	29,911.86
		LESS: COPAYMENT	31,391.91
		REIMBURSEMENT	6,774,635.33
		ALL OTHER	3,741,881.31
		FEE SCHEDULE-LAB	507,523.68
		INJECTABLE DRUGS	2,525,230.34

TOTAL NUMBER OF CLAIMS 10,321

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	311,635.18	7,524.99	OTHER LAB	149,165.00	0.00
MED/SURG SUPPLY	692,973.38	17,350.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	524.00	EDUCATION & TRAINING	5,598.00	1,280.00
RADIOLOGY-DIAGNOSTIC	370,025.00	1,789.00	OTHER THERAPEUTIC SVC	0.00	4,347.00
CT SCAN	1,809,104.00	155,007.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	34,651.00	40,973.00	FEE SCHEDULE LAB	7,546,471.29	1,006,958.00
EKG/ECG	122,777.00	1,794.00	MRI SERVICES	601,494.00	20,725.00
IV THERAPY	3,271,688.00	46,141.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,006,281.00	264,922.00	DURABLE MED. EQUIP.	0.00	1,087.00
LABOR/DELIVERY ROOM	230,795.00	490.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	42,679.00	513.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	440,149.00	17,051.00	AMBULANCE	0.00	0.00
GI SERVICES	44,670.00	3,144.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,705,053.00	72,573.00	SPECIAL SERVICES	0.00	520.00
RECOVERY ROOM	529,287.00	1,347.00	DRUG-SPECIFIC/HOME IV	0.00	512.21
LABORATORY PATHOLOGIC	0.00	4,024.00	INJECTABLE DRUGS	8,860,540.88	2,395,678.42
RADIOLOGY THERAPEUTIC	642,388.00	307.00	HOME HEALTH SERVICES	0.00	167.00
OCCUPATIONAL THERAPY	9,529.00	16,261.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,404.00	8,673.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	46,552.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	824.00	2,399.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	176,943.00	40,760.00	IMPL DEV CHARGE PATIENTS	97,765.00	11,776.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,541,814.00	291,042.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	632,110.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	100,647.00	10,871.00			
AUDIOLOGY	9,774.00	3,055.00			
CARDIOLOGY	110,735.00	36,520.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	70,442.09			
TREATMENT/OBSERV. RM	788,580.44	9,129.00			
			TOTAL ANCILLARY	33,889,550.17	4,614,228.71
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	33,889,550.17	4,614,228.71

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,462,857.54	ADJUSTMENTS	0.00
COVERED CHARGES	990,546.82	CONTRACTUAL ALLOW	407,938.71
NON-COVERD CHARGES	472,310.72	TOTAL MEDICAID LIAB	582,608.11
		LESS: COB	582,035.42
		LESS: COPAYMENT	572.69
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 314

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,594.57	43.00	OTHER LAB	5,159.00	0.00
MED/SURG SUPPLY	40,547.00	11,291.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	248.00	514.00
RADIOLOGY-DIAGNOSTIC	13,050.00	0.00	OTHER THERAPEUTIC SVC	161.00	1,610.00
CT SCAN	45,366.00	26,666.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	186,732.00	29,501.00
EKG/ECG	3,289.00	0.00	MRI SERVICES	11,328.00	0.00
IV THERAPY	95,599.00	4,438.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	69,762.00	92,380.00	DURABLE MED. EQUIP.	0.00	3,677.00
LABOR/DELIVERY ROOM	24,212.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,374.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	35,835.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,991.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	112,344.00	4,815.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	38,843.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	104,337.61	234,040.72
RADIOLOGY THERAPEUTIC	8,676.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	658.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,394.00	585.00	IMPL DEV CHARGE PATIENTS	14,028.00	5,019.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	93,280.00	51,286.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	22,841.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	8,179.00	1,104.00			
AUDIOLOGY	1,228.00	513.00			
CARDIOLOGY	569.00	3,491.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	22,579.64	679.00			
			TOTAL ANCILLARY	990,546.82	472,310.72
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	990,546.82	472,310.72

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	576,003.69	ADJUSTMENTS	1,497.31
COVERED CHARGES	546,883.42	CONTRACTUAL ALLOW	529,430.16
NON-COVERD CHARGES	29,120.27	TOTAL MEDICAID LIAB	17,453.26
		LESS: COB	0.00
		LESS: COPAYMENT	609.00
		REIMBURSEMENT	16,844.26
		TOTAL NUMBER OF CLAIMS	312

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,305.51	2.08	OTHER LAB	728.00	0.00
MED/SURG SUPPLY	5,220.00	77.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,773.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	24,407.00	3,541.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	105,087.00	9,198.00
EKG/ECG	6,877.00	0.00	MRI SERVICES	9,286.00	3,776.00
IV THERAPY	942.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	555.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,754.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	286,968.00	2,837.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	47,337.91	1,871.19
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	2,172.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	31,894.00	7,818.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,577.00	0.00			
			TOTAL ANCILLARY	546,883.42	29,120.27
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	546,883.42	29,120.27

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	50,858.50	ADJUSTMENTS	0.00
COVERED CHARGES	38,854.00	CONTRACTUAL ALLOW	24,014.59
NON-COVERD CHARGES	12,004.50	TOTAL MEDICAID LIAB	14,839.41
		LESS: COB	14,818.41
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	14

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	246.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	520.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,376.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	6,363.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,932.00	3,257.00
EKG/ECG	299.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	68.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,371.00	25.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,110.00	2,291.50
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	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	38,854.00	12,004.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	38,854.00	12,004.50

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,051,875.36	ADJUSTMENTS	397,680.86
COVERED CHARGES	7,263,156.35	CONTRACTUAL ALLOW	5,827,133.82
NON-COVERD CHARGES	788,719.01	TOTAL MEDICAID LIAB	1,436,022.53
		LESS: COB	43,681.95
		LESS: COPAYMENT	1,848.00
		REIMBURSEMENT	1,390,492.58
		TOTAL NUMBER OF CLAIMS	258

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,491.45	1,880.00	OTHER LAB	1,803.00	0.00
MED/SURG SUPPLY	234,376.14	5,719.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	87,531.00	443.00	OTHER THERAPEUTIC SVC	161.00	644.00
CT SCAN	49,434.00	4,077.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,280.00	FEE SCHEDULE LAB	341,665.00	58,303.00
EKG/ECG	5,083.00	299.00	MRI SERVICES	30,767.00	0.00
IV THERAPY	565,374.00	6,308.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	695,296.00	127,338.00	DURABLE MED. EQUIP.	0.00	100.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,277.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	71,556.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,379.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	49,883.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,093,657.40	529,145.01
RADIOLOGY THERAPEUTIC	165,415.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	68.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	613,167.00	40,081.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,474.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	77,117.00	1,450.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	12,031.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	87,864.00	10,246.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	49,354.36	1,338.00			
			TOTAL ANCILLARY	7,263,156.35	788,719.01
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,263,156.35	788,719.01

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	224,007.00	ADJUSTMENTS	0.00
COVERED CHARGES	156,361.50	CONTRACTUAL ALLOW	77,162.36
NON-COVERD CHARGES	67,645.50	TOTAL MEDICAID LIAB	79,199.14
		LESS: COB	79,076.14
		LESS: COPAYMENT	123.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,781.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,574.00	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	3,191.00	50.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,837.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	41,607.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,189.00	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	1,559.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	42,541.50	4,786.50
RADIOLOGY THERAPEUTIC	49,179.00	646.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,774.00	62,163.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,129.00	0.00			
			TOTAL ANCILLARY	156,361.50	67,645.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	156,361.50	67,645.50

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	188,878.86	ADJUSTMENTS	0.00
COVERED CHARGES	183,816.86	CONTRACTUAL ALLOW	103,557.41
NON-COVERD CHARGES	5,062.00	TOTAL MEDICAID LIAB	80,259.45
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	80,259.45

TOTAL NUMBER OF ADMISSIONS 19

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	72		0	35,928.00		1,780.00
ROUTINE NURSERY	0		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	35,928.00		1,780.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	72		0	35,928.00		1,780.00

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 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47,900.24	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	16,074.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	26,625.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,547.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,516.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	913.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,340.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,229.00	0.00	PROFESSIONAL FEES	0.00	3,048.00
OPERATING ROOM	2,000.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,394.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	598.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,227.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	315.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,819.62	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	880.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,909.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,602.00	234.00			
			TOTAL ANCILLARY	147,888.86	3,282.00
			TOTAL ACCOMODATIONS	35,928.00	1,780.00
			TOTAL CHARGES	183,816.86	5,062.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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	08/01/13	THROUGH	07/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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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 08/01/13 THROUGH 07/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	811,881.48	ADJUSTMENTS	19,442.72
COVERED CHARGES	717,357.48	CONTRACTUAL ALLOW	469,223.61
NON-COVERD CHARGES	94,524.00	TOTAL MEDICAID LIAB	248,133.87
		LESS: COB	0.00
		LESS: COPAYMENT	423.00
		REIMBURSEMENT	247,710.87
		ALL OTHER	222,093.55
		FEE SCHEDULE-LAB	22,027.33
		INJECTABLE DRUGS	3,589.99

TOTAL NUMBER OF CLAIMS 855

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 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,109.23	0.00	OTHER LAB	2,829.00	0.00
MED/SURG SUPPLY	26,092.00	16.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	32,540.00	528.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	78,833.00	13,710.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,172.00	899.00	FEE SCHEDULE LAB	173,610.00	50,385.00
EKG/ECG	13,122.00	675.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,754.00	0.00	PROFESSIONAL FEES	0.00	429.00
OPERATING ROOM	13,280.00	3,910.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,324.00	1,321.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,308.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	192,888.00	3,862.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,205.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,083.25	10,607.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	3,402.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,062.00	693.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	88,635.00	855.00	IMPL DEV CHARGE PATIENTS	528.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,774.00	1,585.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	465.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	616.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,077.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,667.00	1,031.00			
			TOTAL ANCILLARY	717,357.48	94,524.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	717,357.48	94,524.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

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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 08/01/13 THROUGH 07/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,315.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,295.00	CONTRACTUAL ALLOW	451.79
NON-COVERD CHARGES	20.00	TOTAL MEDICAID LIAB	1,843.21
		LESS: COB	1,843.21
		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

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 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	288.00	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	500.00	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	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,491.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,295.00	20.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,295.00	20.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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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 08/01/13 THROUGH 07/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	109,094.85	ADJUSTMENTS	147.00
COVERED CHARGES	106,140.85	CONTRACTUAL ALLOW	98,012.84
NON-COVERD CHARGES	2,954.00	TOTAL MEDICAID LIAB	8,128.01
		LESS: COB	0.00
		LESS: COPAYMENT	282.00
		REIMBURSEMENT	7,846.01
		TOTAL NUMBER OF CLAIMS	177

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 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,040.85	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	906.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,285.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,471.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,663.00	1,846.00
EKG/ECG	225.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	258.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	70,198.00	1,108.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,230.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	656.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	208.00	0.00			
			TOTAL ANCILLARY	106,140.85	2,954.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	106,140.85	2,954.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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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 08/01/13 THROUGH 07/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,314.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,294.00	CONTRACTUAL ALLOW	490.84
NON-COVERD CHARGES	20.00	TOTAL MEDICAID LIAB	803.16
		LESS: COB	800.16
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

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 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 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	417.00	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	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	877.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,294.00	20.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,294.00	20.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 08/01/13 THROUGH 07/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	63,617.88	ADJUSTMENTS	0.00
COVERED CHARGES	62,007.88	CONTRACTUAL ALLOW	43,524.23
NON-COVERD CHARGES	1,610.00	TOTAL MEDICAID LIAB	18,483.65
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	18,483.65

TOTAL NUMBER OF CLAIMS 4

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 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	641.88	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	896.00	193.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	320.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,737.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,100.00	228.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	254.00	87.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,614.00	174.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	156.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	50,445.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	616.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	156.00			
			TOTAL ANCILLARY	62,007.88	1,610.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	62,007.88	1,610.00

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

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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	08/01/13	THROUGH	07/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,552,820.89	ADJUSTMENTS	13,299.10
COVERED CHARGES	3,498,769.45	CONTRACTUAL ALLOW	2,476,714.13
NON-COVERD CHARGES	54,051.44	TOTAL MEDICAID LIAB	1,022,055.32
		LESS: COB	9,463.07
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,012,592.25

TOTAL NUMBER OF ADMISSIONS 137

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	313		7	317,382.00		39,418.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	313		7	317,382.00		39,418.00
SPECIAL CARE SERVICES						
CCU	138		3	215,368.17		4,626.00
ICU	39		0	111,540.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	177		3	326,908.17		4,626.00
TOTAL ACCOMODATIONS	490		10	644,290.17		44,044.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	453,768.43	0.00	OTHER LAB	23,539.00	0.00
MED/SURG SUPPLY	142,526.99	73.44	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	617,947.88	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	80,611.00	0.00	OTHER THERAPEUTIC SVC	0.00	1,119.00
CT SCAN	291,481.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	12,548.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	48,112.00	0.00	MRI SERVICES	16,690.00	0.00
IV THERAPY	133,415.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	210,082.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	267,907.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	94,552.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	263,542.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	47,445.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	10,925.16	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	1,965.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,938.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	900.00	3,820.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	3,010.40	0.00	IMPL DEV CHARGE PATIENTS	30,905.08	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	14,229.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	19,361.00	4,392.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	14,751.00	603.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	47,984.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,343.09	0.00			
			TOTAL ANCILLARY	2,854,479.28	10,007.44
			TOTAL ACCOMODATIONS	644,290.17	44,044.00
			TOTAL CHARGES	3,498,769.45	54,051.44

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,781,407.60	ADJUSTMENTS	196,836.03
COVERED CHARGES	7,327,754.02	CONTRACTUAL ALLOW	5,952,413.08
NON-COVERD CHARGES	453,653.58	TOTAL MEDICAID LIAB	1,375,340.94
		LESS: COB	2,327.42
		LESS: COPAYMENT	1,755.00
		REIMBURSEMENT	1,371,258.52
		ALL OTHER	1,297,656.52
		FEE SCHEDULE-LAB	67,702.88
		INJECTABLE DRUGS	5,899.12
		TOTAL NUMBER OF CLAIMS	2,619

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	106,950.03	27,633.50	OTHER LAB	88,869.00	0.00
MED/SURG SUPPLY	57,651.33	2,854.18	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	504,677.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,403,295.00	80,361.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	338.00	FEE SCHEDULE LAB	1,131,197.20	143,491.30
EKG/ECG	97,604.00	1,940.00	MRI SERVICES	484,143.00	25,831.00
IV THERAPY	267,691.00	66,050.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	183,585.00	7,330.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	54,828.00	21,472.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	80,475.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,126,835.00	26,254.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	53,337.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	64,615.25	14,609.62
RADIOLOGY THERAPEUTIC	80,384.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,475.00	2,392.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	34,052.00	280.00	IMPL DEV CHARGE PATIENTS	2,998.50	2,706.37
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	223,620.00	19,690.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,384.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	51,775.00	1,741.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	73,614.00	1,364.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	91,516.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	51,182.71	7,315.61			
			TOTAL ANCILLARY	7,327,754.02	453,653.58
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,327,754.02	453,653.58

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	80,786.35	ADJUSTMENTS	0.00
COVERED CHARGES	72,158.35	CONTRACTUAL ALLOW	48,478.16
NON-COVERD CHARGES	8,628.00	TOTAL MEDICAID LIAB	23,680.19
		LESS: COB	23,667.29
		LESS: COPAYMENT	12.90
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 28

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,050.76	0.00	OTHER LAB	1,173.00	0.00
MED/SURG SUPPLY	1,721.33	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,550.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,267.00	5,726.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	14,757.00	1,552.00
EKG/ECG	1,236.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,532.00	362.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,730.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	476.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,939.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	20,650.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,979.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	513.75	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	1,038.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	190.51	943.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	621.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,734.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	72,158.35	8,628.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	72,158.35	8,628.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	763,429.27	ADJUSTMENTS	859.03
COVERED CHARGES	730,109.13	CONTRACTUAL ALLOW	705,215.84
NON-COVERD CHARGES	33,320.14	TOTAL MEDICAID LIAB	24,893.29
		LESS: COB	0.00
		LESS: COPAYMENT	825.00
		REIMBURSEMENT	24,068.29
		TOTAL NUMBER OF CLAIMS	445

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,763.50	1,200.00	OTHER LAB	2,346.00	0.00
MED/SURG SUPPLY	1,286.88	111.39	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	42,250.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	73,800.00	7,344.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	146,496.00	6,762.00
EKG/ECG	6,208.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	28,348.00	10,976.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,006.00	2,730.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	373,633.00	105.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,962.75	437.75
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	7,035.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	26,974.00	3,654.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	730,109.13	33,320.14
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	730,109.13	33,320.14

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,848.75	ADJUSTMENTS	0.00
COVERED CHARGES	10,813.75	CONTRACTUAL ALLOW	8,313.29
NON-COVERD CHARGES	35.00	TOTAL MEDICAID LIAB	2,500.46
		LESS: COB	2,497.46
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	65.75	0.00	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	1,683.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,345.00	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	5,313.00	35.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	402.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	10,813.75	35.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,813.75	35.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	451,908.25	ADJUSTMENTS	0.00
COVERED CHARGES	451,908.25	CONTRACTUAL ALLOW	403,732.16
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	48,176.09
		LESS: COB	0.00
		LESS: COPAYMENT	264.00
		REIMBURSEMENT	47,912.09

TOTAL NUMBER OF CLAIMS 9

Report : CLM-0812-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	957.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,797.00	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	119,408.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	530.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,926.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,759.00	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	2,948.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	186.25	0.00
RADIOLOGY THERAPEUTIC	301,761.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	636.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	451,908.25	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	451,908.25	0.00

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
 Run Time: 00:17:45
 Page: 1

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	938,573.87	ADJUSTMENTS	37,621.44
COVERED CHARGES	859,803.87	CONTRACTUAL ALLOW	359,757.80
NON-COVERD CHARGES	78,770.00	TOTAL MEDICAID LIAB	500,046.07
		LESS: COB	2,368.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	497,677.57

TOTAL NUMBER OF ADMISSIONS 96

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	345		5	130,730.00		67,881.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	345		5	130,730.00		67,881.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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		5	130,730.00		67,881.00

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
 Run Time: 00:17:45
 Page: 2

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	129,961.87	0.00	OTHER LAB	7,187.00	0.00
MED/SURG SUPPLY	42,790.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	187,635.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,827.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	50,828.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,994.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,657.00	0.00	MRI SERVICES	2,717.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,849.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	20,731.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	46,094.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	270.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	66.00	0.00	INJECTABLE DRUGS	186,182.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	538.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,723.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	277.00
OTHER IMAGING SERVICE	3,771.00	0.00			
BLOOD	11,361.00	0.00			
BLOOD STORAGE & PRO.	432.00	10,612.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	11,460.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	729,073.87	10,889.00
			TOTAL ACCOMODATIONS	130,730.00	67,881.00
			TOTAL CHARGES	859,803.87	78,770.00

Report : CLM-0800-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
696	2214062001920	02/18/14 - 02/21/14	03/10/14	0.00	69.00	0.00	0.00	0.00
696	2214062003508	02/16/14 - 02/20/14	03/10/14	0.00	208.00	0.00	0.00	0.00
TOTAL				0.00	277.00	0.00	0.00	0.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
Run Time: 00:17:47
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,613,744.74	ADJUSTMENTS	112,963.00
COVERED CHARGES	1,409,357.92	CONTRACTUAL ALLOW	888,675.43
NON-COVERD CHARGES	204,386.82	TOTAL MEDICAID LIAB	520,682.49
		LESS: COB	1,668.29
		LESS: COPAYMENT	2,106.00
		REIMBURSEMENT	516,908.20
		ALL OTHER	449,655.15
		FEE SCHEDULE-LAB	60,816.63
		INJECTABLE DRUGS	6,436.42

TOTAL NUMBER OF CLAIMS 1,803

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57,333.02	2,884.17	OTHER LAB	19,375.00	0.00
MED/SURG SUPPLY	46,971.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	674.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	95,285.00	701.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	143,186.00	41,763.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,576.00	573.00	FEE SCHEDULE LAB	401,952.90	112,025.90
EKG/ECG	19,051.00	555.00	MRI SERVICES	15,588.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	95,237.00	1,691.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,309.00	2,862.00	FREE STANDING CLINIC	11,341.00	130.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	259,061.00	7,671.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,955.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	67,094.00	22,959.75
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	1,176.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	177.00	216.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	61,326.00	6,009.00			
BLOOD	2,634.00	0.00			
BLOOD STORAGE & PRO.	0.00	1,516.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	10,505.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	50,166.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	27,235.00	980.00			
			TOTAL ANCILLARY	1,409,357.92	204,386.82
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,409,357.92	204,386.82

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,589.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,691.00	CONTRACTUAL ALLOW	2,989.36
NON-COVERD CHARGES	3,898.00	TOTAL MEDICAID LIAB	1,701.64
		LESS: COB	1,701.64
		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

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	431.00	152.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	268.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	19.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	134.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,780.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,459.00	318.00
EKG/ECG	222.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	108.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,057.00	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	12.00	23.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	449.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,691.00	3,898.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,691.00	3,898.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	124,786.48	ADJUSTMENTS	1,942.18
COVERED CHARGES	114,048.98	CONTRACTUAL ALLOW	99,285.42
NON-COVERD CHARGES	10,737.50	TOTAL MEDICAID LIAB	14,763.56
		LESS: COB	8.00
		LESS: COPAYMENT	669.00
		REIMBURSEMENT	14,086.56
		TOTAL NUMBER OF CLAIMS	327

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,348.48	151.00	OTHER LAB	360.00	0.00
MED/SURG SUPPLY	2,053.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,441.00	97.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,636.00	1,871.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	23,849.50	5,692.50
EKG/ECG	999.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	555.00	0.00	FREE STANDING CLINIC	106.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	60,224.00	499.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,806.00	1,256.00
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	1,248.00	1,144.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,423.00	27.00			
			TOTAL ANCILLARY	114,048.98	10,737.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	114,048.98	10,737.50

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 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	909.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	96.00	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	391.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,396.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,396.00	0.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,669.00	ADJUSTMENTS	0.00
COVERED CHARGES	12,436.00	CONTRACTUAL ALLOW	7,583.13
NON-COVERD CHARGES	233.00	TOTAL MEDICAID LIAB	4,852.87
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	4,849.87
		TOTAL NUMBER OF CLAIMS	1

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	161.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	678.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	109.00	233.00	OTHER THERAPEUTIC SVC	0.00	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	10,328.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	726.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	142.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	292.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	12,436.00	233.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,436.00	233.00

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
Run Time: 00:18:02
Page: 15

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	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE I
 INPATIENT PAID CLAIMS

Run Date: 07/15/2015
 Run Time: 00:18:09
 Page: 1

PERRY HOSPITAL
 1120 MORNINGSIDE DR
 PERRY,GA 31069-2906

PROVIDER NUMBER
 000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,400,380.26	ADJUSTMENTS	48,450.76
COVERED CHARGES	1,400,185.06	CONTRACTUAL ALLOW	918,292.20
NON-COVERD CHARGES	195.20	TOTAL MEDICAID LIAB	481,892.86
		LESS: COB	13,636.69
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	468,256.17
		TOTAL NUMBER OF ADMISSIONS	68

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	306		0	195,534.00		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	306		0	195,534.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	43		0	79,650.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	43		0	79,650.00		0.00
TOTAL ACCOMODATIONS	349		0	275,184.00		0.00

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	148,961.21	0.00	OTHER LAB	10,896.00	0.00
MED/SURG SUPPLY	7,934.16	195.20	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	342,152.81	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	43,635.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	180,213.27	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	27,195.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	29,800.00	0.00	MRI SERVICES	46,794.00	0.00
IV THERAPY	707.40	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	36,550.35	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	87,576.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,490.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	61,049.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,416.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,382.00	0.00	INJECTABLE DRUGS	692.10	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,514.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	264.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,863.69	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,315.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,635.72	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,273.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	48,396.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,566.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,729.35	0.00			
			TOTAL ANCILLARY	1,125,001.06	195.20
			TOTAL ACCOMODATIONS	275,184.00	0.00
			TOTAL CHARGES	1,400,185.06	195.20

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,918.54	ADJUSTMENTS	0.00
COVERED CHARGES	13,918.54	CONTRACTUAL ALLOW	6,230.72
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	7,687.82
		LESS: COB	7,687.82
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	10		0	6,390.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	10		0	6,390.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	10		0	6,390.00		0.00

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,007.95	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	65.04	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,621.87	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	512.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	601.68	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	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	7,528.54	0.00
			TOTAL ACCOMODATIONS	6,390.00	0.00
			TOTAL CHARGES	13,918.54	0.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
Run Time: 00:18:12
Page: 5

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,657,312.87	ADJUSTMENTS	89,854.69
COVERED CHARGES	2,374,183.33	CONTRACTUAL ALLOW	1,896,050.38
NON-COVERD CHARGES	283,129.54	TOTAL MEDICAID LIAB	478,132.95
		LESS: COB	3,180.87
		LESS: COPAYMENT	1,640.95
		REIMBURSEMENT	473,311.13
		ALL OTHER	415,781.43
		FEE SCHEDULE-LAB	45,064.58
		INJECTABLE DRUGS	12,465.12
		TOTAL NUMBER OF CLAIMS	1,392

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,207.39	48.93	OTHER LAB	75,015.00	0.00
MED/SURG SUPPLY	14,128.33	2,304.89	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	151,436.84	3,070.00	OTHER THERAPEUTIC SVC	0.00	166.00
CT SCAN	504,224.00	92,057.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	817.03	FEE SCHEDULE LAB	514,944.10	131,927.98
EKG/ECG	49,703.00	894.00	MRI SERVICES	43,621.00	0.00
IV THERAPY	54,475.00	1,968.00	PROFESSIONAL FEES	0.00	59.40
OPERATING ROOM	158,517.96	34,997.63	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	15,664.00	1,335.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	20,639.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	545,549.05	615.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	36,612.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	52,219.61	4,661.68
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	605.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	739.81	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	53,302.23	5,211.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	925.60	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	52,301.00	2,391.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	917.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,041.41	0.00			
			TOTAL ANCILLARY	2,374,183.33	283,129.54
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,374,183.33	283,129.54

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
Run Time: 00:18:22
Page: 7

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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	63,400.73	ADJUSTMENTS	0.00
COVERED CHARGES	46,572.82	CONTRACTUAL ALLOW	24,063.79
NON-COVERD CHARGES	16,827.91	TOTAL MEDICAID LIAB	22,509.03
		LESS: COB	22,455.03
		LESS: COPAYMENT	54.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 47

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	654.62	12.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	76.87	63.53	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,455.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,438.00	4,579.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	14,962.13	2,166.00
EKG/ECG	894.00	0.00	MRI SERVICES	0.00	5,185.00
IV THERAPY	2,280.00	0.00	PROFESSIONAL FEES	0.00	59.40
OPERATING ROOM	0.00	3,437.96	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	123.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,752.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	492.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	445.20	419.02
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	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	906.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	46,572.82	16,827.91
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	46,572.82	16,827.91

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
Run Time: 00:18:23
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PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	68,139.62	ADJUSTMENTS	385.58
COVERED CHARGES	66,911.63	CONTRACTUAL ALLOW	61,093.88
NON-COVERD CHARGES	1,227.99	TOTAL MEDICAID LIAB	5,817.75
		LESS: COB	0.00
		LESS: COPAYMENT	141.00
		REIMBURSEMENT	5,676.75
		TOTAL NUMBER OF CLAIMS	104

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	105.47	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	21.95	63.53	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,020.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,528.00	1,150.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,104.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	158.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	54,504.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	590.21	14.46
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	880.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	66,911.63	1,227.99
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	66,911.63	1,227.99

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,054.38	ADJUSTMENTS	0.00
COVERED CHARGES	8,990.38	CONTRACTUAL ALLOW	5,873.82
NON-COVERD CHARGES	64.00	TOTAL MEDICAID LIAB	3,116.56
		LESS: COB	3,110.56
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	10

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	117.08	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	419.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,053.00	64.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,045.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	100.30	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	0.00			
			TOTAL ANCILLARY	8,990.38	64.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,990.38	64.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
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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	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL
 417 W 3RD AVE
 ALBANY,GA 31701-1943

PROVIDER NUMBER 000001482A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	66,885,602.34	ADJUSTMENTS	2,667,981.37
COVERED CHARGES	63,613,847.32	CONTRACTUAL ALLOW	43,669,879.60
NON-COVERD CHARGES	3,271,755.02	TOTAL MEDICAID LIAB	19,943,967.72
		LESS: COB	46,695.96
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	19,897,271.76

TOTAL NUMBER OF ADMISSIONS 2,113

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	10,308		5	4,921,915.00		1,161,683.00
ROUTINE NURSERY	875		0	383,534.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	11,183		5	5,305,449.00		1,161,683.00
SPECIAL CARE SERVICES						
CCU	485		0	640,200.00		0.00
ICU	1,385		0	1,779,548.00		0.00
NICU	767		0	1,016,201.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,637		0	3,435,949.00		0.00
TOTAL ACCOMODATIONS	13,820		5	8,741,398.00		1,161,683.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL
 417 W 3RD AVE
 ALBANY,GA 31701-1943

PROVIDER NUMBER
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,775,227.42	18,742.96	OTHER LAB	326,566.00	0.00
MED/SURG SUPPLY	5,668,993.96	118,373.30	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,595,870.41	63,297.00	EDUCATION & TRAINING	1,334.00	0.00
RADIOLOGY-DIAGNOSTIC	1,063,596.00	3,567.00	OTHER THERAPEUTIC SVC	0.00	22,415.00
CT SCAN	985,527.00	815,446.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	451,698.82	1,486.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	240,670.60	638.40	MRI SERVICES	469,246.90	76.10
IV THERAPY	111,737.00	1,218.00	PROFESSIONAL FEES	0.00	2,105.00
OPERATING ROOM	4,136,323.29	37,407.00	DURABLE MED. EQUIP.	0.00	1,378.00
LABOR/DELIVERY ROOM	118,836.00	2,000.00	REHAB THERAPY	8,500.00	0.00
RESPIRATORY SERVICES	2,789,102.00	1,262.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	399,492.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	244,478.00	4,526.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,840,579.00	12,005.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,058,358.85	1,271.15	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	183,884.00	0.00	INJECTABLE DRUGS	3,636,834.71	7,484.56
RADIOLOGY THERAPEUTIC	416,258.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	179,084.56	1,490.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	65,050.56	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	237,881.00	19,104.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	402.00	124,305.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	478,270.00	0.00	IMPL DEV CHARGE PATIENTS	2,762,710.00	338.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	39,288.00
OTHER IMAGING SERVICE	262,443.00	4,250.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	809,472.00	777,942.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	224,209.00	0.00			
AUDIOLOGY	62,650.00	125.00			
CARDIOLOGY	1,565,041.00	1,431.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	29,701.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	672,421.24	27,100.55			
			TOTAL ANCILLARY	54,872,449.32	2,110,072.02
			TOTAL ACCOMODATIONS	8,741,398.00	1,161,683.00
			TOTAL CHARGES	63,613,847.32	3,271,755.02

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL
 417 W 3RD AVE
 ALBANY,GA 31701-1943

PROVIDER NUMBER
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013231055280	08/09/13 - 08/13/13	08/26/13	0.00	2,171.00	0.00	0.00	0.00
615	2013294026805	09/15/13 - 09/24/13	10/28/13	0.00	2,171.00	0.00	0.00	0.00
615	2013311089997	10/15/13 - 10/31/13	11/11/13	0.00	2,171.00	0.00	0.00	0.00
3001	2213354003023	08/21/13 - 08/23/13	12/23/13	0.00	20.00	0.00	0.00	0.00
615	2014051086068	01/28/14 - 02/11/14	02/24/14	0.00	2,171.00	0.00	0.00	0.00
615	2014085064327	02/03/14 - 02/06/14	03/31/14	0.00	2,171.00	0.00	0.00	0.00
615	2014093092512	10/06/13 - 10/09/13	04/07/14	0.00	2,171.00	0.00	0.00	0.00
615	2014106073543	03/22/14 - 03/25/14	04/21/14	0.00	2,171.00	0.00	0.00	0.00
615	2014154059542	01/04/14 - 01/10/14	06/09/14	0.00	4,532.00	0.00	0.00	0.00
615	2214174002961	12/04/13 - 12/09/13	06/30/14	0.00	2,171.00	0.00	0.00	0.00
615	2014244011933	02/03/14 - 02/06/14	09/08/14	0.00	2,171.00	0.00	0.00	0.00
615	5214268000160	12/12/13 - 12/27/13	09/29/14	0.00	2,171.00	0.00	0.00	0.00
615	5214282007219	03/04/14 - 03/19/14	10/13/14	0.00	2,171.00	0.00	0.00	0.00
615	2014318002133	03/08/14 - 03/11/14	11/17/14	0.00	2,171.00	0.00	0.00	0.00
615	2014325000097	11/16/13 - 11/21/13	11/24/14	0.00	2,171.00	0.00	0.00	0.00
615	2014338009173	03/04/14 - 03/07/14	12/08/14	0.00	2,171.00	0.00	0.00	0.00
615	2015020005589	03/21/14 - 03/29/14	01/26/15	0.00	2,171.00	0.00	0.00	0.00
615	2015113074516	06/16/14 - 06/25/14	04/27/15	0.00	2,171.00	0.00	0.00	0.00
TOTAL				0.00	39,288.00	0.00	0.00	0.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL
 417 W 3RD AVE
 ALBANY,GA 31701-1943

PROVIDER NUMBER
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	411,917.71	ADJUSTMENTS	0.00
COVERED CHARGES	402,096.71	CONTRACTUAL ALLOW	99,120.02
NON-COVERD CHARGES	9,821.00	TOTAL MEDICAID LIAB	302,976.69
		LESS: COB	302,976.69
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 15

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	52		0	24,440.00		0.00
ROUTINE NURSERY	34		0	17,132.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	86		0	41,572.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	4		0	5,280.00		0.00
NICU	31		0	35,185.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	35		0	40,465.00		0.00
TOTAL ACCOMODATIONS	121		0	82,037.00		0.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL
 417 W 3RD AVE
 ALBANY,GA 31701-1943

PROVIDER NUMBER
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	105,983.38	0.00	OTHER LAB	4,165.00	0.00
MED/SURG SUPPLY	39,122.53	1,032.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	47,095.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,697.00	0.00	OTHER THERAPEUTIC SVC	0.00	165.00
CT SCAN	3,124.00	3,482.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,816.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	930.00	0.00	MRI SERVICES	3,042.00	0.00
IV THERAPY	4,892.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,564.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,278.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	22,856.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,610.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,713.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,943.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	432.00	0.00	INJECTABLE DRUGS	11,390.78	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	97.02	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	0.00	220.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,158.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,211.00	0.00			
BLOOD	1,721.00	0.00			
BLOOD STORAGE & PRO.	1,555.00	3,588.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	794.00	0.00			
AUDIOLOGY	1,050.00	0.00			
CARDIOLOGY	4,002.00	1,334.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	722.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,096.00	0.00			
			TOTAL ANCILLARY	320,059.71	9,821.00
			TOTAL ACCOMODATIONS	82,037.00	0.00
			TOTAL CHARGES	402,096.71	9,821.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/13 THROUGH 07/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	40,373,108.86	ADJUSTMENTS	856,525.16
COVERED CHARGES	37,035,332.78	CONTRACTUAL ALLOW	28,669,192.79
NON-COVERD CHARGES	3,337,776.08	TOTAL MEDICAID LIAB	8,366,139.99
		LESS: COB	9,420.55
		LESS: COPAYMENT	32,660.61
		REIMBURSEMENT	8,324,058.83
		ALL OTHER	6,931,613.32
		FEE SCHEDULE-LAB	492,325.96
		INJECTABLE DRUGS	900,119.55
		TOTAL NUMBER OF CLAIMS	17,188

PHOEBE PUTNEY MEMORIAL HOSPITAL
 417 W 3RD AVE
 ALBANY,GA 31701-1943

PROVIDER NUMBER
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,764,841.29	5,741.87	OTHER LAB	181,706.00	5,669.00
MED/SURG SUPPLY	2,901,661.65	19,532.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	3,246.82	EDUCATION & TRAINING	2,320.00	108.00
RADIOLOGY-DIAGNOSTIC	934,458.00	19,829.00	OTHER THERAPEUTIC SVC	0.00	2,946.00
CT SCAN	2,330,261.00	89,357.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	71,559.00	23,151.21	FEE SCHEDULE LAB	2,857,164.08	753,342.60
EKG/ECG	247,728.00	23,064.00	MRI SERVICES	723,433.00	25,739.00
IV THERAPY	1,171,580.00	14,977.00	PROFESSIONAL FEES	0.00	224.00
OPERATING ROOM	2,481,350.00	328,087.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	92,590.00	0.00	REHAB THERAPY	850.00	0.00
RESPIRATORY SERVICES	248,186.00	143,243.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	356,986.00	910.00	AMBULANCE	0.00	0.00
GI SERVICES	654,259.67	46,723.34	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,338,826.00	73,154.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,264,031.00	7,243.00	DRUG-SPECIFIC/HOME IV	0.00	7,600.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,131,311.66	1,387,165.09
RADIOLOGY THERAPEUTIC	2,637,473.00	11,611.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,380.00	3,757.10	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	20,315.00	9,838.23	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,955.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,109,656.00	56,535.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	140,880.00	800.00	IMPL DEV CHARGE PATIENTS	436,886.00	0.00
LITHOTRIpsy	83,590.00	0.00	NO CC/INVALID REV CODE	0.00	3,205.00
OTHER IMAGING SERVICE	751,439.00	51,979.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	138,485.00	2.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	688,607.00	2,837.00			
AUDIOLOGY	3,613.00	393.00			
CARDIOLOGY	506,244.00	83,990.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	403,467.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	354,195.43	128,820.82			
			TOTAL ANCILLARY	37,035,332.78	3,337,776.08
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	37,035,332.78	3,337,776.08

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/13 THROUGH 07/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5914062000227	11/07/13 - 11/07/13	03/10/14	0.00	2,171.00	0.00	0.00	0.00
9921	2214113014434	01/22/14 - 01/31/14	04/28/14	0.00	166.00	0.00	0.00	0.00
8685	5914134000265	11/12/13 - 11/12/13	05/19/14	0.00	94.00	0.00	0.00	0.00
9641	5914224000771	06/19/14 - 06/30/14	08/18/14	0.00	774.00	0.00	0.00	0.00
TOTAL				0.00	3,205.00	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/13 THROUGH 07/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	563,498.02	ADJUSTMENTS	0.00
COVERED CHARGES	484,023.20	CONTRACTUAL ALLOW	228,064.94
NON-COVERD CHARGES	79,474.82	TOTAL MEDICAID LIAB	255,958.26
		LESS: COB	255,651.02
		LESS: COPAYMENT	307.24
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 208

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE PUTNEY MEMORIAL HOSPITAL
 417 W 3RD AVE
 ALBANY,GA 31701-1943

PROVIDER NUMBER
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,452.50	0.00	OTHER LAB	833.00	1,650.00
MED/SURG SUPPLY	51,225.00	33.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	142.00	EDUCATION & TRAINING	96.00	0.00
RADIOLOGY-DIAGNOSTIC	18,900.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,569.00	17,534.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	156.00	3,325.00	FEE SCHEDULE LAB	42,992.13	8,331.22
EKG/ECG	2,671.00	186.00	MRI SERVICES	14,137.00	3,042.00
IV THERAPY	5,517.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	59,881.00	9,900.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,538.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,106.00	387.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,890.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,668.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	52,886.00	1,136.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	32,859.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	75,677.07	8,477.70
RADIOLOGY THERAPEUTIC	2,554.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	574.00	4,616.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	504.00	4,906.03	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	6,083.00	814.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,309.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,600.00	10,361.00			
BLOOD	645.00	0.00			
BLOOD STORAGE & PRO.	1,100.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,516.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,004.00	1,617.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	11,729.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,351.50	3,016.87			
			TOTAL ANCILLARY	484,023.20	79,474.82
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	484,023.20	79,474.82

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/13 THROUGH 07/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,103,792.15	ADJUSTMENTS	632.28
COVERED CHARGES	1,051,694.05	CONTRACTUAL ALLOW	986,356.13
NON-COVERD CHARGES	52,098.10	TOTAL MEDICAID LIAB	65,337.92
		LESS: COB	0.00
		LESS: COPAYMENT	2,442.00
		REIMBURSEMENT	62,895.92
		TOTAL NUMBER OF CLAIMS	1,168

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE PUTNEY MEMORIAL HOSPITAL
 417 W 3RD AVE
 ALBANY,GA 31701-1943

PROVIDER NUMBER
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	64,120.04	151.70	OTHER LAB	2,737.00	0.00
MED/SURG SUPPLY	28,499.78	107.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	64,883.00	787.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	52,303.00	6,288.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	592.00	FEE SCHEDULE LAB	83,390.00	28,595.00
EKG/ECG	8,370.00	186.00	MRI SERVICES	5,450.00	6,084.00
IV THERAPY	3,022.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,934.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	426.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	672.00	850.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	400.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	688,717.00	3,824.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	25,013.73	1,706.90
RADIOLOGY THERAPEUTIC	662.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	470.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,127.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,216.00	1,273.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,161.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,668.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,452.50	1,653.50			
			TOTAL ANCILLARY	1,051,694.05	52,098.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,051,694.05	52,098.10

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/13 THROUGH 07/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,782.90	ADJUSTMENTS	0.00
COVERED CHARGES	9,945.90	CONTRACTUAL ALLOW	2,836.49
NON-COVERD CHARGES	837.00	TOTAL MEDICAID LIAB	7,109.41
		LESS: COB	7,100.41
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE PUTNEY MEMORIAL HOSPITAL
 417 W 3RD AVE
 ALBANY,GA 31701-1943

PROVIDER NUMBER
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	444.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	462.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,188.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,099.00	753.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	84.00	84.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,854.00	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	480.40	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	1,334.00	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	0.00	0.00			
			TOTAL ANCILLARY	9,945.90	837.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,945.90	837.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/13 THROUGH 07/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,222,838.72	ADJUSTMENTS	311,645.46
COVERED CHARGES	7,801,737.33	CONTRACTUAL ALLOW	6,734,174.64
NON-COVERD CHARGES	421,101.39	TOTAL MEDICAID LIAB	1,067,562.69
		LESS: COB	0.00
		LESS: COPAYMENT	1,453.57
		REIMBURSEMENT	1,066,109.12

TOTAL NUMBER OF CLAIMS 189

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL
 417 W 3RD AVE
 ALBANY,GA 31701-1943

PROVIDER NUMBER
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	239,181.66	0.00	OTHER LAB	0.00	2,871.00
MED/SURG SUPPLY	338,631.54	393.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	108.00	0.00
RADIOLOGY-DIAGNOSTIC	26,334.00	10,874.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,152.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	72,182.12	15,090.80
EKG/ECG	11,494.00	1,116.00	MRI SERVICES	0.00	3,042.00
IV THERAPY	227,061.00	4,824.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	378,318.00	57,067.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	170.00
RESPIRATORY SERVICES	8,909.00	84.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	44,258.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,920.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	17,512.00	1,889.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	140,676.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,323,992.63	109,504.35
RADIOLOGY THERAPEUTIC	292,777.00	522.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	554.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	19,613.00	286.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	555.00	0.00	IMPL DEV CHARGE PATIENTS	926,124.00	53,625.00
LITHOTRIpsy	148,030.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,547.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,490.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,091.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	501,352.00	150,609.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	38,428.38	8,580.24			
			TOTAL ANCILLARY	7,801,737.33	421,101.39
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,801,737.33	421,101.39

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
Run Time: 00:21:15
Page: 17

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/13 THROUGH 07/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	31,350.98	ADJUSTMENTS	0.00
COVERED CHARGES	27,248.98	CONTRACTUAL ALLOW	6,177.03
NON-COVERD CHARGES	4,102.00	TOTAL MEDICAID LIAB	21,071.95
		LESS: COB	21,071.95
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL
 417 W 3RD AVE
 ALBANY,GA 31701-1943

PROVIDER NUMBER
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,766.58	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,241.00	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	3,482.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	555.00	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	9,900.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,080.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,301.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,108.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	491.40	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	806.00	0.00
LITHOTRIPTY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	600.00			
			TOTAL ANCILLARY	27,248.98	4,102.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	27,248.98	4,102.00

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
 Run Time: 00:21:27
 Page: 1

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,881,795.26	ADJUSTMENTS	293,293.18
COVERED CHARGES	6,727,574.42	CONTRACTUAL ALLOW	4,858,477.18
NON-COVERD CHARGES	154,220.84	TOTAL MEDICAID LIAB	1,869,097.24
		LESS: COB	12,444.19
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,856,653.05

TOTAL NUMBER OF ADMISSIONS 240

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	651		0	589,155.00		36,855.00
ROUTINE NURSERY	59		0	38,721.00		4,025.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	710		0	627,876.00		40,880.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	171		0	403,389.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	171		0	403,389.00		0.00
TOTAL ACCOMODATIONS	881		0	1,031,265.00		40,880.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,306,027.22	0.00	OTHER LAB	55,583.00	0.00
MED/SURG SUPPLY	121,750.53	13,896.84	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,095,625.00	6,618.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	153,553.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	633,212.00	5,186.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	22,893.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	65,305.00	0.00	MRI SERVICES	83,511.00	0.00
IV THERAPY	9,633.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	509,839.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	131,642.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	358,201.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	73,844.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	50,417.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	369,543.00	4,367.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	106,576.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	769.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,242.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,607.00	311.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	116,338.07	26,942.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	48,879.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	187,440.00	52,482.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	25,434.00	3,538.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	116,934.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	43,511.60	0.00			
			TOTAL ANCILLARY	5,696,309.42	113,340.84
			TOTAL ACCOMODATIONS	1,031,265.00	40,880.00
			TOTAL CHARGES	6,727,574.42	154,220.84

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
 Run Time: 00:21:31
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	37,948.78	ADJUSTMENTS	0.00
COVERED CHARGES	37,398.78	CONTRACTUAL ALLOW	18,448.78
NON-COVERD CHARGES	550.00	TOTAL MEDICAID LIAB	18,950.00
		LESS: COB	18,950.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	10		0	9,050.00		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	10		0	9,050.00		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	10		0	9,050.00		550.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,954.78	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	23.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,329.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	135.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,008.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	899.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	28,348.78	0.00
			TOTAL ACCOMODATIONS	9,050.00	550.00
			TOTAL CHARGES	37,398.78	550.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
Run Time: 00:21:32
Page: 5

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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,490,377.20	ADJUSTMENTS	397,758.01
COVERED CHARGES	9,280,499.04	CONTRACTUAL ALLOW	7,443,079.45
NON-COVERD CHARGES	1,209,878.16	TOTAL MEDICAID LIAB	1,837,419.59
		LESS: COB	12,855.74
		LESS: COPAYMENT	3,279.36
		REIMBURSEMENT	1,821,284.49
		ALL OTHER	1,733,755.73
		FEE SCHEDULE-LAB	73,402.60
		INJECTABLE DRUGS	14,126.16
		TOTAL NUMBER OF CLAIMS	2,771

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	220,926.73	34,930.50	OTHER LAB	113,031.00	0.00
MED/SURG SUPPLY	203,812.58	17,190.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	540,803.00	21,885.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,858,400.00	298,837.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,334.03	FEE SCHEDULE LAB	1,115,770.50	163,765.70
EKG/ECG	122,578.00	2,202.00	MRI SERVICES	575,142.00	27,630.00
IV THERAPY	38,490.00	2,051.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	780,935.00	197,950.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	49,648.00	0.00	REHAB THERAPY	0.00	1,850.00
RESPIRATORY SERVICES	47,297.00	13,126.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	133,594.00	857.00	AMBULANCE	0.00	0.00
GI SERVICES	197,955.00	41,724.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,687,349.00	45,000.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	355,532.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	103,080.86	123,061.66
RADIOLOGY THERAPEUTIC	5,050.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	716.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	926.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	16,741.00	7,168.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	8,383.67	43,752.17
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	318,160.00	41,565.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	62,598.00	12,260.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	199,988.00	57,368.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	246,984.00	29,255.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	92,434.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	185,815.70	23,473.00			
			TOTAL ANCILLARY	9,280,499.04	1,209,878.16
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,280,499.04	1,209,878.16

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

Run Date: 07/15/2015
Run Time: 00:21:51
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	170,251.30	ADJUSTMENTS	0.00
COVERED CHARGES	128,777.79	CONTRACTUAL ALLOW	76,127.94
NON-COVERD CHARGES	41,473.51	TOTAL MEDICAID LIAB	52,649.85
		LESS: COB	52,615.73
		LESS: COPAYMENT	34.12
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 37

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,432.74	240.00	OTHER LAB	3,346.00	0.00
MED/SURG SUPPLY	6,517.85	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,508.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,738.00	19,274.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	16,841.00	4,087.00
EKG/ECG	367.00	367.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	18,126.00	11,413.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,231.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	555.00	156.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,252.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	25,452.00	1,255.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	15,324.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	585.00	476.51
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	1,029.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	391.20	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,098.00	3,735.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,856.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,128.00	470.00			
			TOTAL ANCILLARY	128,777.79	41,473.51
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	128,777.79	41,473.51

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
Run Time: 00:21:52
Page: 9

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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	573,574.96	ADJUSTMENTS	529.40
COVERED CHARGES	522,749.47	CONTRACTUAL ALLOW	501,436.33
NON-COVERD CHARGES	50,825.49	TOTAL MEDICAID LIAB	21,313.14
		LESS: COB	0.00
		LESS: COPAYMENT	759.00
		REIMBURSEMENT	20,554.14
		TOTAL NUMBER OF CLAIMS	381

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,804.76	521.00	OTHER LAB	5,942.00	0.00
MED/SURG SUPPLY	4,269.67	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	36,207.00	451.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	48,930.00	37,844.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	98,732.00	7,266.00
EKG/ECG	4,404.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,315.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,591.00	468.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,064.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	283,124.00	1,994.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,101.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,229.84	2,281.49
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,754.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,281.20	0.00			
			TOTAL ANCILLARY	522,749.47	50,825.49
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	522,749.47	50,825.49

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
Run Time: 00:21:55
Page: 11

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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,850.81	ADJUSTMENTS	0.00
COVERED CHARGES	22,277.80	CONTRACTUAL ALLOW	9,824.24
NON-COVERD CHARGES	1,573.01	TOTAL MEDICAID LIAB	12,453.56
		LESS: COB	12,435.56
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	10

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	773.80	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	6,496.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,346.00	827.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,569.00	698.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	45.00	48.01
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	1,048.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	22,277.80	1,573.01
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	22,277.80	1,573.01

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	690,205.77	ADJUSTMENTS	37,058.09
COVERED CHARGES	654,860.91	CONTRACTUAL ALLOW	544,385.86
NON-COVERD CHARGES	35,344.86	TOTAL MEDICAID LIAB	110,475.05
		LESS: COB	0.00
		LESS: COPAYMENT	192.00
		REIMBURSEMENT	110,283.05
		TOTAL NUMBER OF CLAIMS	21

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39,285.00	4,830.40	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	85,519.87	2,925.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,447.00	1,437.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,012.00	3,393.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	388.00	FEE SCHEDULE LAB	17,125.00	1,807.00
EKG/ECG	1,835.00	367.00	MRI SERVICES	0.00	0.00
IV THERAPY	21,257.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	277,804.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,077.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,399.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	50,370.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,208.00	235.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	87,024.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,202.45	3,058.55
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,416.19	13,236.91
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,085.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	20,746.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,152.00	1,396.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,650.00	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	15,331.40	1,186.00			
			TOTAL ANCILLARY	654,860.91	35,344.86
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	654,860.91	35,344.86

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
Run Time: 00:21:57
Page: 15

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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF 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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	60,314,636.02	ADJUSTMENTS	6,140,152.25
COVERED CHARGES	58,359,081.01	CONTRACTUAL ALLOW	42,445,887.84
NON-COVERD CHARGES	1,955,555.01	TOTAL MEDICAID LIAB	15,913,193.17
		LESS: COB	241,543.31
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	15,671,649.86

TOTAL NUMBER OF ADMISSIONS 832

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	4,954		2	4,570,168.00		377,930.00
ROUTINE NURSERY	385		5	610,458.00		16,360.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5,339		7	5,180,626.00		394,290.00
SPECIAL CARE SERVICES						
CCU	303		0	776,984.00		2,029.00
ICU	699		0	1,893,646.00		7,713.00
NICU	330		0	850,080.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,332		0	3,520,710.00		9,742.00
TOTAL ACCOMODATIONS	6,671		7	8,701,336.00		404,032.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,015,646.08	74,340.83	OTHER LAB	394,514.00	1,155.00
MED/SURG SUPPLY	2,333,273.43	779,612.01	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,355,631.75	285,791.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,815,077.00	6,974.00	OTHER THERAPEUTIC SVC	0.00	870.00
CT SCAN	2,251,481.00	14,688.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	356,458.02	6,248.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	401,935.00	0.00	MRI SERVICES	910,308.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,535,902.00	41,803.00	DURABLE MED. EQUIP.	0.00	279.00
LABOR/DELIVERY ROOM	111,467.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,364,982.00	19,554.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	742,790.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	584,136.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,283,368.00	22,596.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	394,021.00	15,509.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	311,360.00	0.00	INJECTABLE DRUGS	31,107.63	0.00
RADIOLOGY THERAPEUTIC	44,018.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	131,435.00	6,943.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	92,930.00	4,564.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,002,476.00	40,508.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	14,847.00	47,765.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,732,454.48	3,507.17
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	59,798.00
OTHER IMAGING SERVICE	292,507.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,681,814.00	93,545.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	235,944.00	23,432.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,291,684.00	2,041.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	56,240.00	0.00			
ORGAN ACQUISITION	655,055.00	0.00			
TREATMENT/OBSERV. RM	232,882.62	0.00			
			TOTAL ANCILLARY	49,657,745.01	1,551,523.01
			TOTAL ACCOMODATIONS	8,701,336.00	404,032.00
			TOTAL CHARGES	58,359,081.01	1,955,555.01

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE I
 INPATIENT PAID CLAIMS

Run Date: 07/15/2015
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PIEDMONT HOSPITAL
 1968 PEACHTREE RD NW
 ATLANTA,GA 30309-1281

PROVIDER NUMBER
 000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013323032577	11/07/13 - 11/16/13	11/25/13	0.00	4,782.00	0.00	0.00	0.00
614	2213326003702	10/31/13 - 11/08/13	11/25/13	0.00	4,782.00	0.00	0.00	0.00
614	2014052054757	10/03/13 - 10/09/13	02/24/14	0.00	3,996.00	0.00	0.00	0.00
614	2214097000261	03/11/14 - 03/12/14	04/14/14	0.00	3,996.00	0.00	0.00	0.00
614	2214139011127	05/05/14 - 05/09/14	05/26/14	0.00	4,782.00	0.00	0.00	0.00
614	2014174009159	06/12/14 - 06/17/14	06/30/14	0.00	4,351.00	0.00	0.00	0.00
614	5214181000122	10/14/13 - 11/01/13	07/07/14	0.00	3,996.00	0.00	0.00	0.00
614	2014184051635	01/20/14 - 02/03/14	07/07/14	0.00	4,351.00	0.00	0.00	0.00
614	5214185000056	10/10/13 - 10/25/13	07/14/14	0.00	3,996.00	0.00	0.00	0.00
614	2014199048069	09/23/13 - 10/01/13	07/21/14	0.00	3,996.00	0.00	0.00	0.00
614	2014225029947	04/25/14 - 05/06/14	08/18/14	0.00	3,996.00	0.00	0.00	0.00
614	2014234060677	10/05/13 - 10/08/13	08/25/14	0.00	3,996.00	0.00	0.00	0.00
614	5914263000022	04/16/14 - 05/16/14	09/29/14	0.00	3,996.00	0.00	0.00	0.00
614	2014311049392	02/22/14 - 02/26/14	11/10/14	0.00	4,782.00	0.00	0.00	0.00
TOTAL				0.00	59,798.00	0.00	0.00	0.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	912,893.78	ADJUSTMENTS	0.00
COVERED CHARGES	903,190.78	CONTRACTUAL ALLOW	264,820.79
NON-COVERD CHARGES	9,703.00	TOTAL MEDICAID LIAB	638,369.99
		LESS: COB	638,369.99
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 22

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	77		0	72,380.00		3,298.00
ROUTINE NURSERY	89		0	151,620.00		6,405.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	166		0	224,000.00		9,703.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	4		0	10,284.00		0.00
NICU	45		0	115,920.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	49		0	126,204.00		0.00
TOTAL ACCOMODATIONS	215		0	350,204.00		9,703.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	112,673.02	0.00	OTHER LAB	4,774.00	0.00
MED/SURG SUPPLY	35,482.42	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	112,502.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	30,114.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,890.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,206.00	0.00	MRI SERVICES	21,080.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	56,697.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	34,336.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	57,302.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,416.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,639.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	32,787.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	5,802.00	0.00	INJECTABLE DRUGS	413.34	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	671.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,296.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,399.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,304.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	976.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,227.00	0.00			
			TOTAL ANCILLARY	552,986.78	0.00
			TOTAL ACCOMODATIONS	350,204.00	9,703.00
			TOTAL CHARGES	903,190.78	9,703.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,092,950.91	ADJUSTMENTS	570,551.93
COVERED CHARGES	15,676,848.34	CONTRACTUAL ALLOW	12,698,825.06
NON-COVERD CHARGES	5,416,102.57	TOTAL MEDICAID LIAB	2,978,023.28
		LESS: COB	115,079.14
		LESS: COPAYMENT	6,251.24
		REIMBURSEMENT	2,856,692.90
		ALL OTHER	2,438,663.72
		FEE SCHEDULE-LAB	291,382.75
		INJECTABLE DRUGS	126,646.43

TOTAL NUMBER OF CLAIMS 5,824

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	318,002.67	103,620.43	OTHER LAB	170,670.00	1,089.00
MED/SURG SUPPLY	326,923.94	290,418.44	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	751.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	766,040.00	31,709.00	OTHER THERAPEUTIC SVC	0.00	1,450.00
CT SCAN	1,740,403.00	399,460.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	840.00	6,481.00	FEE SCHEDULE LAB	3,333,704.00	982,694.50
EKG/ECG	221,611.00	8,844.00	MRI SERVICES	547,917.00	45,959.00
IV THERAPY	53,476.00	1,566.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	966,122.00	264,981.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	23,136.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	83,961.00	13,585.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	111,901.00	1,359.00	AMBULANCE	0.00	0.00
GI SERVICES	245,893.00	62,667.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,076,541.00	74,639.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	199,393.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	864,846.91	959,708.80
RADIOLOGY THERAPEUTIC	471,097.00	215,900.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,556.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	996.00	1,886.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	40,508.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	256,167.00	4,596.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	104,294.90	849,258.60
LITHOTRIPSY	21,455.00	0.00	NO CC/INVALID REV CODE	0.00	15,339.00
OTHER IMAGING SERVICE	479,092.00	68,764.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	124,169.00	20,859.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	332,082.00	74,250.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	946,415.00	868,701.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	582,503.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	307,195.92	2,502.80			
			TOTAL ANCILLARY	15,676,848.34	5,416,102.57
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,676,848.34	5,416,102.57

Report : CLM-0804-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

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PIEDMONT HOSPITAL
 1968 PEACHTREE RD NW
 ATLANTA,GA 30309-1281

PROVIDER NUMBER
 000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014072025207	03/10/14 - 03/10/14	03/17/14	0.00	3,996.00	0.00	0.00	0.00
614	2014072025207	03/10/14 - 03/10/14	03/17/14	0.00	355.00	0.00	0.00	0.00
614	2014157046184	06/03/14 - 06/03/14	06/09/14	0.00	4,782.00	0.00	0.00	0.00
948	2014162073705	05/13/14 - 05/13/14	06/16/14	0.00	356.00	0.00	0.00	0.00
948	2014162073705	05/15/14 - 05/15/14	06/16/14	0.00	356.00	0.00	0.00	0.00
948	2014162073705	05/27/14 - 05/27/14	06/16/14	0.00	356.00	0.00	0.00	0.00
948	2014162073705	05/29/14 - 05/29/14	06/16/14	0.00	356.00	0.00	0.00	0.00
614	2315084000087	05/21/14 - 05/21/14	04/13/15	0.00	4,782.00	0.00	0.00	0.00
TOTAL				0.00	15,339.00	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

Run Date: 07/15/2015
Run Time: 00:22:47
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	583,234.80	ADJUSTMENTS	0.00
COVERED CHARGES	359,675.44	CONTRACTUAL ALLOW	169,415.26
NON-COVERD CHARGES	223,559.36	TOTAL MEDICAID LIAB	190,260.18
		LESS: COB	190,110.56
		LESS: COPAYMENT	149.62
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 82

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,361.17	1,640.00	OTHER LAB	7,566.00	0.00
MED/SURG SUPPLY	24,847.03	4,908.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,926.00	598.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	34,784.00	55,276.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	378.00	FEE SCHEDULE LAB	42,488.00	14,843.00
EKG/ECG	4,020.00	0.00	MRI SERVICES	6,067.00	0.00
IV THERAPY	348.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	58,291.00	17,316.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,646.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,941.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,396.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,757.00	9,292.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	41,713.00	1,952.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,227.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18,077.70	14,551.86
RADIOLOGY THERAPEUTIC	657.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,871.00	1,497.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,520.00	70,000.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	3,996.00
OTHER IMAGING SERVICE	8,173.00	1,355.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	1,227.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	13,195.00	24,729.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	17,858.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,945.54	0.00			
			TOTAL ANCILLARY	359,675.44	223,559.36
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	359,675.44	223,559.36

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

Run Date: 07/15/2015
Run Time: 00:22:47
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014056035508	09/04/13 - 09/04/13	03/03/14	0.00	3,996.00	0.00	3,609.30	0.00
TOTAL				0.00	3,996.00	0.00	3,609.30	0.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
Run Time: 00:22:49
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PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	351,440.33	ADJUSTMENTS	370.58
COVERED CHARGES	323,319.73	CONTRACTUAL ALLOW	312,299.55
NON-COVERD CHARGES	28,120.60	TOTAL MEDICAID LIAB	11,020.18
		LESS: COB	0.00
		LESS: COPAYMENT	492.00
		REIMBURSEMENT	10,528.18
		TOTAL NUMBER OF CLAIMS	197

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,234.97	410.00	OTHER LAB	7,329.00	0.00
MED/SURG SUPPLY	2,153.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	32,957.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,129.00	12,638.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	54,212.00	4,945.00
EKG/ECG	5,226.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,898.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	941.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,361.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	172,317.00	3,090.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	662.56	2,072.60
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	9,620.00	4,913.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,757.00	52.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,522.20	0.00			
			TOTAL ANCILLARY	323,319.73	28,120.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	323,319.73	28,120.60

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,944.30	ADJUSTMENTS	0.00
COVERED CHARGES	2,944.30	CONTRACTUAL ALLOW	2,340.29
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	604.01
		LESS: COB	601.01
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	161.30	0.00	OTHER LAB	0.00	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	1,508.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	1,150.00	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	2,944.30	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,944.30	0.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,719,536.09	ADJUSTMENTS	52,103.16
COVERED CHARGES	2,233,113.86	CONTRACTUAL ALLOW	1,905,010.78
NON-COVERD CHARGES	486,422.23	TOTAL MEDICAID LIAB	328,103.08
		LESS: COB	28,488.38
		LESS: COPAYMENT	555.00
		REIMBURSEMENT	299,059.70

TOTAL NUMBER OF CLAIMS 52

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	43,299.41	5,293.60	OTHER LAB	1,482.00	0.00
MED/SURG SUPPLY	63,761.53	96,182.66	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	77,425.00	8,907.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	41,820.00	3,076.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	40,587.00	13,258.00
EKG/ECG	4,422.00	2,010.00	MRI SERVICES	10,854.00	0.00
IV THERAPY	434.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	527,490.00	27,894.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,793.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	26,618.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,740.00	434.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	46,645.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	155,241.58	50,068.97
RADIOLOGY THERAPEUTIC	459,689.00	108,367.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	436.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	467,591.14	98,382.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	14,977.00	1,186.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,358.00	279.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	215,299.00	71,084.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	26,151.20	0.00			
			TOTAL ANCILLARY	2,233,113.86	486,422.23
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,233,113.86	486,422.23

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
Run Time: 00:22:55
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	45,315.06	ADJUSTMENTS	0.00
COVERED CHARGES	45,032.06	CONTRACTUAL ALLOW	21,902.59
NON-COVERD CHARGES	283.00	TOTAL MEDICAID LIAB	23,129.47
		LESS: COB	23,126.47
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	836.03	240.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	687.03	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,112.00	28.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,597.00	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	1,217.00	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	3,163.00	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	0.00	0.00	IMPL DEV CHARGE PATIENTS	28,420.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	45,032.06	283.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	45,032.06	283.00

HOSPITAL AUTHORITY OF FLOYD COUNTY
 424 N MAIN ST
 CEDARTOWN,GA 30125-2644

PROVIDER NUMBER 000001526A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	75,247.75	ADJUSTMENTS	5,379.81
COVERED CHARGES	75,047.75	CONTRACTUAL ALLOW	48,821.94
NON-COVERD CHARGES	200.00	TOTAL MEDICAID LIAB	26,225.81
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	26,225.81

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	20		0	11,000.00		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	20		0	11,000.00		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	20		0	11,000.00		0.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF FLOYD COUNTY
 424 N MAIN ST
 CEDARTOWN,GA 30125-2644

PROVIDER NUMBER
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,503.25	0.00	OTHER LAB	623.00	0.00
MED/SURG SUPPLY	6,039.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	21,743.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,388.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	750.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,013.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	218.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,769.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18,342.50	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	200.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	659.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	64,047.75	200.00
			TOTAL ACCOMODATIONS	11,000.00	0.00
			TOTAL CHARGES	75,047.75	200.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF FLOYD COUNTY
424 N MAIN ST
CEDARTOWN,GA 30125-2644

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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HOSPITAL AUTHORITY OF FLOYD COUNTY
424 N MAIN ST
CEDARTOWN,GA 30125-2644

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,074,110.89	ADJUSTMENTS	85,735.71
COVERED CHARGES	4,608,603.89	CONTRACTUAL ALLOW	3,602,334.01
NON-COVERD CHARGES	465,507.00	TOTAL MEDICAID LIAB	1,006,269.88
		LESS: COB	415.47
		LESS: COPAYMENT	795.00
		REIMBURSEMENT	1,005,059.41
		ALL OTHER	906,334.83
		FEE SCHEDULE-LAB	86,370.12
		INJECTABLE DRUGS	12,354.46
		TOTAL NUMBER OF CLAIMS	2,880

HOSPITAL AUTHORITY OF FLOYD COUNTY
 424 N MAIN ST
 CEDARTOWN,GA 30125-2644

PROVIDER NUMBER
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,878.25	0.00	OTHER LAB	12,421.00	0.00
MED/SURG SUPPLY	112,630.50	6,211.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	320,561.00	2,869.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	376,367.00	93,019.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,676.00	228.00	FEE SCHEDULE LAB	1,014,451.84	239,433.00
EKG/ECG	53,535.00	2,000.00	MRI SERVICES	0.00	0.00
IV THERAPY	38,688.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,013.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	740.00
RESPIRATORY SERVICES	9,016.00	4,318.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,326,903.00	52,589.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	182,693.30	37,693.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	22,746.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,576.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	18,051.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,585.00	2,200.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	16,215.00	18,589.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	62,597.00	5,618.00			
			TOTAL ANCILLARY	4,608,603.89	465,507.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,608,603.89	465,507.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HOSPITAL AUTHORITY OF FLOYD COUNTY
424 N MAIN ST
CEDARTOWN,GA 30125-2644

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	71,393.50	ADJUSTMENTS	0.00
COVERED CHARGES	63,588.50	CONTRACTUAL ALLOW	25,987.91
NON-COVERD CHARGES	7,805.00	TOTAL MEDICAID LIAB	37,600.59
		LESS: COB	37,600.59
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 41

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HOSPITAL AUTHORITY OF FLOYD COUNTY
 424 N MAIN ST
 CEDARTOWN,GA 30125-2644

PROVIDER NUMBER
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	453.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,719.00	207.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,332.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,560.00	4,264.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,784.00	1,872.00
EKG/ECG	500.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,432.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	128.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	38,910.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,670.50	1,066.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,100.00	396.00			
			TOTAL ANCILLARY	63,588.50	7,805.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	63,588.50	7,805.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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HOSPITAL AUTHORITY OF FLOYD COUNTY
424 N MAIN ST
CEDARTOWN,GA 30125-2644

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	640,690.05	ADJUSTMENTS	711.00
COVERED CHARGES	618,104.05	CONTRACTUAL ALLOW	592,233.95
NON-COVERD CHARGES	22,586.00	TOTAL MEDICAID LIAB	25,870.10
		LESS: COB	0.00
		LESS: COPAYMENT	1,123.00
		REIMBURSEMENT	24,747.10
		TOTAL NUMBER OF CLAIMS	537

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

HOSPITAL AUTHORITY OF FLOYD COUNTY
 424 N MAIN ST
 CEDARTOWN,GA 30125-2644

PROVIDER NUMBER
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	763.50	0.00	OTHER LAB	623.00	0.00
MED/SURG SUPPLY	5,406.00	557.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	33,854.00	195.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,129.00	8,944.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	72,040.00	9,474.00
EKG/ECG	2,195.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	448.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	467,612.00	1,902.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,517.55	1,514.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	516.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	618,104.05	22,586.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	618,104.05	22,586.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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HOSPITAL AUTHORITY OF FLOYD COUNTY
424 N MAIN ST
CEDARTOWN,GA 30125-2644

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	31,837.00	ADJUSTMENTS	0.00
COVERED CHARGES	31,772.00	CONTRACTUAL ALLOW	24,366.90
NON-COVERD CHARGES	65.00	TOTAL MEDICAID LIAB	7,405.10
		LESS: COB	7,376.10
		LESS: COPAYMENT	29.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	34

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HOSPITAL AUTHORITY OF FLOYD COUNTY
 424 N MAIN ST
 CEDARTOWN,GA 30125-2644

PROVIDER NUMBER
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 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	102.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	944.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,388.00	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	28,888.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	157.00	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	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	293.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	31,772.00	65.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	31,772.00	65.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOSPITAL AUTHORITY OF FLOYD COUNTY
424 N MAIN ST
CEDARTOWN,GA 30125-2644

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	28,226.50	ADJUSTMENTS	4,959.21
COVERED CHARGES	26,157.50	CONTRACTUAL ALLOW	21,198.29
NON-COVERD CHARGES	2,069.00	TOTAL MEDICAID LIAB	4,959.21
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,959.21

TOTAL NUMBER OF CLAIMS 1

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOSPITAL AUTHORITY OF FLOYD COUNTY
 424 N MAIN ST
 CEDARTOWN,GA 30125-2644

PROVIDER NUMBER
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	242.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	374.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	375.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,680.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,265.00	653.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,980.00	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	2,302.00	187.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,761.00	437.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,178.00	792.00			
			TOTAL ANCILLARY	26,157.50	2,069.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	26,157.50	2,069.00

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOSPITAL AUTHORITY OF FLOYD COUNTY
424 N MAIN ST
CEDARTOWN,GA 30125-2644

PROVIDER NUMBER
000001526A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
 Run Time: 00:23:43
 Page: 1

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	473,738.10	ADJUSTMENTS	15,248.81
COVERED CHARGES	467,153.92	CONTRACTUAL ALLOW	147,389.93
NON-COVERD CHARGES	6,584.18	TOTAL MEDICAID LIAB	319,763.99
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	319,763.99

TOTAL NUMBER OF ADMISSIONS 57

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	158		0	54,950.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	158		0	54,950.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	9		0	6,075.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	6,075.00		0.00
TOTAL ACCOMODATIONS	167		0	61,025.00		0.00

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	121,958.28	0.00	OTHER LAB	1,590.76	0.00
MED/SURG SUPPLY	63,874.73	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	66,531.07	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,207.69	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	36,656.50	5,770.06	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	863.46	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,578.47	0.00	MRI SERVICES	7,182.79	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,865.24	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	37,898.02	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,790.36	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	26,171.39	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,935.14	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	440.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,317.58	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,883.22	814.12			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,600.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,784.22	0.00			
			TOTAL ANCILLARY	406,128.92	6,584.18
			TOTAL ACCOMODATIONS	61,025.00	0.00
			TOTAL CHARGES	467,153.92	6,584.18

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	914,315.40	ADJUSTMENTS	23,462.72
COVERED CHARGES	824,997.42	CONTRACTUAL ALLOW	537,390.67
NON-COVERD CHARGES	89,317.98	TOTAL MEDICAID LIAB	287,606.75
		LESS: COB	958.46
		LESS: COPAYMENT	561.00
		REIMBURSEMENT	286,087.29
		ALL OTHER	258,475.29
		FEE SCHEDULE-LAB	24,992.90
		INJECTABLE DRUGS	2,619.10

TOTAL NUMBER OF CLAIMS 912

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,637.25	19,681.90	OTHER LAB	43,100.94	0.00
MED/SURG SUPPLY	31,503.11	659.51	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,875.86	549.54	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	162,270.02	15,125.36	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,011.23	117.00	FEE SCHEDULE LAB	141,533.00	29,897.95
EKG/ECG	11,413.13	434.46	MRI SERVICES	23,873.67	2,993.92
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	30,853.67	3,559.39	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,023.84	2,028.64	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	30,620.68	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	225,314.91	1,555.56	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,191.06	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	24,264.95	9,656.96
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	209.63	448.97	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	17,970.30	1,713.92			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,063.71	828.05			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,300.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,966.46	66.85			
			TOTAL ANCILLARY	824,997.42	89,317.98
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	824,997.42	89,317.98

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,029.80	ADJUSTMENTS	0.00
COVERED CHARGES	7,168.94	CONTRACTUAL ALLOW	4,543.62
NON-COVERD CHARGES	860.86	TOTAL MEDICAID LIAB	2,625.32
		LESS: COB	2,625.32
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 4

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	90.00	96.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	267.55	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	322.44	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,423.46	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,480.76	505.30
EKG/ECG	323.08	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,784.88	113.56	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	312.00	146.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	164.77	0.00			
			TOTAL ANCILLARY	7,168.94	860.86
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,168.94	860.86

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	83,620.13	ADJUSTMENTS	344.50
COVERED CHARGES	79,099.20	CONTRACTUAL ALLOW	72,255.41
NON-COVERD CHARGES	4,520.93	TOTAL MEDICAID LIAB	6,843.79
		LESS: COB	12.60
		LESS: COPAYMENT	351.00
		REIMBURSEMENT	6,480.19
		TOTAL NUMBER OF CLAIMS	155

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,367.50	862.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	899.50	337.59	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,463.83	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,776.28	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,948.60	1,352.86
EKG/ECG	362.05	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	222.80	133.68	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	49,636.67	21.43	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,535.98	1,123.98
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	29.53	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	659.86			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	885.99	0.00			
			TOTAL ANCILLARY	79,099.20	4,520.93
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	79,099.20	4,520.93

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,020.18	ADJUSTMENTS	0.00
COVERED CHARGES	1,060.38	CONTRACTUAL ALLOW	652.23
NON-COVERD CHARGES	959.80	TOTAL MEDICAID LIAB	408.15
		LESS: COB	408.15
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 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	0.00	0.00
MED/SURG SUPPLY	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	942.66	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	233.97	17.14
EKG/ECG	72.41	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	750.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,060.38	959.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,060.38	959.80

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,725.09	ADJUSTMENTS	0.00
COVERED CHARGES	24,013.17	CONTRACTUAL ALLOW	18,989.93
NON-COVERD CHARGES	1,711.92	TOTAL MEDICAID LIAB	5,023.24
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	5,017.24

TOTAL NUMBER OF CLAIMS 1

Report : CLM-0812-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	817.00	1,358.20	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	15,497.82	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	373.21	209.87
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,303.19	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,818.64	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	430.03	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	504.00	77.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	269.28	66.85			
			TOTAL ANCILLARY	24,013.17	1,711.92
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	24,013.17	1,711.92

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
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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	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF 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 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,837,044.77	ADJUSTMENTS	11,014.58
COVERED CHARGES	1,807,709.73	CONTRACTUAL ALLOW	838,581.33
NON-COVERD CHARGES	29,335.04	TOTAL MEDICAID LIAB	969,128.40
		LESS: COB	12,398.43
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	956,729.97

TOTAL NUMBER OF ADMISSIONS 164

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	363		0	188,760.00		16,400.00
ROUTINE NURSERY	57		0	29,640.00		570.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	420		0	218,400.00		16,970.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	130		0	165,490.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	130		0	165,490.00		0.00
TOTAL ACCOMODATIONS	550		0	383,890.00		16,970.00

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 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	241,501.85	0.00	OTHER LAB	11,895.00	0.00
MED/SURG SUPPLY	121,061.87	146.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	256,001.00	0.00	EDUCATION & TRAINING	1.00	0.00
RADIOLOGY-DIAGNOSTIC	36,927.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	64,693.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	12,094.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,637.00	0.00	MRI SERVICES	12,965.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	166,647.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	17,195.50	550.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	67,652.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	38,701.50	0.00	AMBULANCE	0.00	4,886.54
GI SERVICES	9,220.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	76,839.33	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	16,250.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	163.30	0.00	INJECTABLE DRUGS	168,098.10	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,556.51	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	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	242.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	30,068.27	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,927.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	5,820.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,106.50	720.50			
AUDIOLOGY	7,020.00	0.00			
CARDIOLOGY	30,715.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	15,391.00	0.00			
			TOTAL ANCILLARY	1,423,819.73	12,365.04
			TOTAL ACCOMODATIONS	383,890.00	16,970.00
			TOTAL CHARGES	1,807,709.73	29,335.04

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 04/01/13 THROUGH 03/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/13 THROUGH 03/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,365,896.41	ADJUSTMENTS	56,478.24
COVERED CHARGES	2,113,760.84	CONTRACTUAL ALLOW	1,615,009.33
NON-COVERD CHARGES	252,135.57	TOTAL MEDICAID LIAB	498,751.51
		LESS: COB	1,424.13
		LESS: COPAYMENT	3,183.00
		REIMBURSEMENT	494,144.38
		ALL OTHER	414,686.40
		FEE SCHEDULE-LAB	72,612.07
		INJECTABLE DRUGS	6,845.91
		TOTAL NUMBER OF CLAIMS	2,340

TAYLOR REGIONAL HOSPITAL
 222 PERRY HWY
 HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
 000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	68,213.30	8,682.00	OTHER LAB	23,259.50	678.00
MED/SURG SUPPLY	72,785.64	1,619.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	685.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	116,797.00	1,896.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	176,890.00	25,052.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,904.00	3,302.00	FEE SCHEDULE LAB	437,819.00	128,418.07
EKG/ECG	16,689.00	2,376.50	MRI SERVICES	146,272.00	0.00
IV THERAPY	16,698.50	1,980.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	206,994.85	24,258.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,075.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,366.50	3,975.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	86,723.85	0.00	AMBULANCE	0.00	0.00
GI SERVICES	62,922.50	6,843.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	318,948.00	5,876.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	31,177.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	72,986.70	17,496.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	420.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	35,860.00	1,228.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	729.00	143.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	64,987.50	2,032.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	2,328.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	41,757.50	12,259.50			
AUDIOLOGY	0.00	585.00			
CARDIOLOGY	50,218.50	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	47,685.50	0.00			
			TOTAL ANCILLARY	2,113,760.84	252,135.57
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,113,760.84	252,135.57

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

Run Date: 07/15/2015
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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 04/01/13 THROUGH 03/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,962.50	ADJUSTMENTS	0.00
COVERED CHARGES	24,455.00	CONTRACTUAL ALLOW	11,353.51
NON-COVERD CHARGES	5,507.50	TOTAL MEDICAID LIAB	13,101.49
		LESS: COB	13,077.49
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 32

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 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	442.50	217.50	OTHER LAB	339.00	0.00
MED/SURG SUPPLY	595.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,272.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,456.00	2,304.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	220.00	FEE SCHEDULE LAB	7,056.50	2,554.00
EKG/ECG	480.50	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	6,317.00	49.50	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	1,298.00	80.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,032.50	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	945.50	82.50			
			TOTAL ANCILLARY	24,455.00	5,507.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	24,455.00	5,507.50

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
Run Time: 00:24:32
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TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/13 THROUGH 03/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	100,656.30	ADJUSTMENTS	739.39
COVERED CHARGES	96,208.80	CONTRACTUAL ALLOW	86,476.09
NON-COVERD CHARGES	4,447.50	TOTAL MEDICAID LIAB	9,732.71
		LESS: COB	0.00
		LESS: COPAYMENT	381.02
		REIMBURSEMENT	9,351.69
		TOTAL NUMBER OF CLAIMS	186

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 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,759.80	122.00	OTHER LAB	339.00	0.00
MED/SURG SUPPLY	855.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,818.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,279.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,498.00	3,553.50
EKG/ECG	396.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	148.50	44.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	194.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	61,197.50	198.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,257.00	530.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,219.50	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	247.50	0.00			
			TOTAL ANCILLARY	96,208.80	4,447.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	96,208.80	4,447.50

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 04/01/13 THROUGH 03/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,377.50	ADJUSTMENTS	0.00
COVERED CHARGES	1,377.50	CONTRACTUAL ALLOW	949.43
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	428.07
		LESS: COB	425.07
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	108.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	95.50	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	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	355.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,377.50	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,377.50	0.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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	04/01/13	THROUGH	03/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
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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	04/01/13	THROUGH	03/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
 196 RIDGECREST CIR
 CLAYTON,GA 30525-4111

PROVIDER NUMBER 000001559A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	364,785.49	ADJUSTMENTS	30,416.30
COVERED CHARGES	338,116.49	CONTRACTUAL ALLOW	200,149.64
NON-COVERD CHARGES	26,669.00	TOTAL MEDICAID LIAB	137,966.85
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	137,966.85

TOTAL NUMBER OF ADMISSIONS 28

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	87		6	37,206.00		20,169.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	87		6	37,206.00		20,169.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	87		6	37,206.00		20,169.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
 196 RIDGECREST CIR
 CLAYTON,GA 30525-4111

PROVIDER NUMBER
 000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35,167.24	0.00	OTHER LAB	3,055.00	0.00
MED/SURG SUPPLY	33,483.08	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	74,863.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,344.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	24,822.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,920.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	29,339.64	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,220.00	6,500.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,045.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,360.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,000.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	34,481.29	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	36.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,411.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,736.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	17,627.24	0.00			
			TOTAL ANCILLARY	300,910.49	6,500.00
			TOTAL ACCOMODATIONS	37,206.00	20,169.00
			TOTAL CHARGES	338,116.49	26,669.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
196 RIDGECREST CIR
CLAYTON,GA 30525-4111

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
Run Time: 00:24:43
Page: 4

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
196 RIDGECREST CIR
CLAYTON,GA 30525-4111

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	919,567.45	ADJUSTMENTS	166,978.49
COVERED CHARGES	747,777.15	CONTRACTUAL ALLOW	446,158.23
NON-COVERD CHARGES	171,790.30	TOTAL MEDICAID LIAB	301,618.92
		LESS: COB	855.40
		LESS: COPAYMENT	810.00
		REIMBURSEMENT	299,953.52
		ALL OTHER	278,631.59
		FEE SCHEDULE-LAB	20,010.51
		INJECTABLE DRUGS	1,311.42

TOTAL NUMBER OF CLAIMS 645

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
 196 RIDGECREST CIR
 CLAYTON,GA 30525-4111

PROVIDER NUMBER
 000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,658.48	11,610.91	OTHER LAB	7,291.00	559.00
MED/SURG SUPPLY	46,225.46	14.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	39,598.00	1,966.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	92,520.00	43,356.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	175,883.70	56,361.30
EKG/ECG	9,660.00	2,800.00	MRI SERVICES	8,456.00	0.00
IV THERAPY	52,357.40	8,342.40	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	51,445.30	22,691.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,508.00	2,281.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	66.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	125,192.80	1,240.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,000.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	27,302.41	5,621.19
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,000.00
OTHER IMAGING SERVICE	13,681.60	640.00			
BLOOD	4,155.00	976.00			
BLOOD STORAGE & PRO.	2,638.00	290.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,472.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	58,666.00	12,041.50			
			TOTAL ANCILLARY	747,777.15	171,790.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	747,777.15	171,790.30

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
Run Time: 00:24:43
Page: 6

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
196 RIDGECREST CIR
CLAYTON,GA 30525-4111

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014184079193	06/27/14 - 06/27/14	07/07/14	0.00	1,000.00	0.00	0.00	0.00
TOTAL				0.00	1,000.00	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

Run Date: 07/15/2015
Run Time: 00:24:48
Page: 7

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
196 RIDGECREST CIR
CLAYTON,GA 30525-4111

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,866.92	ADJUSTMENTS	0.00
COVERED CHARGES	12,149.32	CONTRACTUAL ALLOW	3,562.78
NON-COVERD CHARGES	5,717.60	TOTAL MEDICAID LIAB	8,586.54
		LESS: COB	8,582.44
		LESS: COPAYMENT	4.10
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 7

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
 196 RIDGECREST CIR
 CLAYTON,GA 30525-4111

PROVIDER NUMBER
 000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	151.04	73.48	OTHER LAB	559.00	0.00
MED/SURG SUPPLY	626.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	833.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,316.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,768.00	1,603.00
EKG/ECG	420.00	280.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	213.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	55.00	149.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,974.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	645.88	449.12
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	0.00	450.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,184.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,117.30	0.00			
			TOTAL ANCILLARY	12,149.32	5,717.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,149.32	5,717.60

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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Page: 9

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
196 RIDGECREST CIR
CLAYTON,GA 30525-4111

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	36,571.29	ADJUSTMENTS	326.00
COVERED CHARGES	31,332.37	CONTRACTUAL ALLOW	29,432.37
NON-COVERD CHARGES	5,238.92	TOTAL MEDICAID LIAB	1,900.00
		LESS: COB	0.00
		LESS: COPAYMENT	96.00
		REIMBURSEMENT	1,804.00
		TOTAL NUMBER OF CLAIMS	38

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
 196 RIDGECREST CIR
 CLAYTON,GA 30525-4111

PROVIDER NUMBER
 000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	531.04	237.48	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,614.69	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,596.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,413.00	3,221.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,680.00	1,545.00
EKG/ECG	560.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	158.00	153.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	55.00	29.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,880.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	828.64	53.44
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,016.00	0.00			
			TOTAL ANCILLARY	31,332.37	5,238.92
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	31,332.37	5,238.92

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
196 RIDGECREST CIR
CLAYTON,GA 30525-4111

PROVIDER NUMBER
000001559A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII

Run Date: 07/15/2015
Run Time: 00:24:49
Page: 12

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
196 RIDGECREST CIR
CLAYTON,GA 30525-4111

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	38,653.18	ADJUSTMENTS	14,376.18
COVERED CHARGES	33,839.18	CONTRACTUAL ALLOW	19,457.00
NON-COVERD CHARGES	4,814.00	TOTAL MEDICAID LIAB	14,382.18
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	14,376.18
		TOTAL NUMBER OF CLAIMS	3

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
 196 RIDGECREST CIR
 CLAYTON,GA 30525-4111

PROVIDER NUMBER
 000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,747.71	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,054.15	12.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	552.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,265.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,581.00	2,247.00
EKG/ECG	280.00	560.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,887.00	375.20	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	66.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,240.00	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	976.82	830.80
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	144.00	450.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,111.50	273.00			
			TOTAL ANCILLARY	33,839.18	4,814.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	33,839.18	4,814.00

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
196 RIDGECREST CIR
CLAYTON,GA 30525-4111

PROVIDER NUMBER
000001559A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF 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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	33,285,130.24	ADJUSTMENTS	184,393.13
COVERED CHARGES	32,740,762.24	CONTRACTUAL ALLOW	25,830,940.09
NON-COVERD CHARGES	544,368.00	TOTAL MEDICAID LIAB	6,909,822.15
		LESS: COB	36,821.58
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,873,000.57

TOTAL NUMBER OF ADMISSIONS 551

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,198		0	1,908,858.00		337,517.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,198		0	1,908,858.00		337,517.00
SPECIAL CARE SERVICES						
CCU	278		0	523,503.20		0.00
ICU	299		0	602,300.80		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	577		0	1,125,804.00		0.00
TOTAL ACCOMODATIONS	3,775		0	3,034,662.00		337,517.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,338,047.24	0.00	OTHER LAB	203,177.00	0.00
MED/SURG SUPPLY	2,540,920.86	4,587.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,718,409.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	861,644.00	0.00	OTHER THERAPEUTIC SVC	0.00	6,609.00
CT SCAN	1,451,741.00	30,894.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	416,949.18	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	312,220.00	0.00	MRI SERVICES	350,534.00	0.00
IV THERAPY	59,026.00	115.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,386,800.00	15,810.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,707,912.00	174.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	511,045.00	0.00	AMBULANCE	0.00	934.00
GI SERVICES	89,736.00	1,273.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,047,874.00	212.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	375,255.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	258,833.00	0.00	INJECTABLE DRUGS	3,384,021.73	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	253,224.11	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	98,895.13	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	100,340.00	6,398.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,007.00	1,036.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,649,166.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	148,846.00	9,408.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	295,009.00	64,244.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	426,508.00	65,157.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,648,995.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	25,872.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	41,092.99	0.00			
			TOTAL ANCILLARY	29,706,100.24	206,851.00
			TOTAL ACCOMODATIONS	3,034,662.00	337,517.00
			TOTAL CHARGES	32,740,762.24	544,368.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

Run Date: 07/15/2015
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 Page: 3

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	67,087.78	ADJUSTMENTS	0.00
COVERED CHARGES	66,818.78	CONTRACTUAL ALLOW	18,109.92
NON-COVERD CHARGES	269.00	TOTAL MEDICAID LIAB	48,708.86
		LESS: COB	48,708.86
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7		0	4,179.00		269.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	7		0	4,179.00		269.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	7		0	4,179.00		269.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	568.37	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,024.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,631.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	633.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	2,188.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,131.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,283.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,278.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,765.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,841.41	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,100.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,810.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	15,280.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,107.00	0.00			
			TOTAL ANCILLARY	62,639.78	0.00
			TOTAL ACCOMODATIONS	4,179.00	269.00
			TOTAL CHARGES	66,818.78	269.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,443,487.96	ADJUSTMENTS	150,489.64
COVERED CHARGES	12,674,538.11	CONTRACTUAL ALLOW	10,531,166.38
NON-COVERD CHARGES	1,768,949.85	TOTAL MEDICAID LIAB	2,143,371.73
		LESS: COB	0.00
		LESS: COPAYMENT	5,058.53
		REIMBURSEMENT	2,138,313.20
		ALL OTHER	1,973,837.26
		FEE SCHEDULE-LAB	97,697.23
		INJECTABLE DRUGS	66,778.71
		TOTAL NUMBER OF CLAIMS	3,113

Report : CLM-0804-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	147,266.58	1,613.73	OTHER LAB	58,919.00	0.00
MED/SURG SUPPLY	504,123.75	11,215.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	431.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	802,593.00	0.00	OTHER THERAPEUTIC SVC	0.00	1,696.00
CT SCAN	1,841,899.00	193,201.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	158,890.00	148,344.00	FEE SCHEDULE LAB	2,825,901.80	513,070.00
EKG/ECG	226,868.00	13,165.00	MRI SERVICES	188,300.00	15,771.00
IV THERAPY	516,431.00	89,061.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	746,623.83	122,181.17	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	60,789.00	348.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	247,562.00	4,184.00	AMBULANCE	0.00	0.00
GI SERVICES	86,732.00	4,774.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,277,201.00	67,238.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	236,204.00	1,977.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	350,706.15	64,341.55
RADIOLOGY THERAPEUTIC	30,441.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	62,458.00	39,266.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,317.00	4,924.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	148.00	1,658.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	112,907.00	568.00
LITHOTRIPSY	65,142.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	171,913.00	3,606.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	82,503.00	3,962.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	243,063.00	72,876.40			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	312,834.00	360,894.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,095.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	311,707.00	28,584.00			
			TOTAL ANCILLARY	12,674,538.11	1,768,949.85
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,674,538.11	1,768,949.85

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	340,746.15	ADJUSTMENTS	0.00
COVERED CHARGES	234,910.53	CONTRACTUAL ALLOW	147,195.12
NON-COVERD CHARGES	105,835.62	TOTAL MEDICAID LIAB	87,715.41
		LESS: COB	87,628.41
		LESS: COPAYMENT	87.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 54

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,722.81	0.00	OTHER LAB	1,814.00	0.00
MED/SURG SUPPLY	11,344.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,601.00	633.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,862.00	41,868.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,918.00	494.00	FEE SCHEDULE LAB	55,342.00	10,492.00
EKG/ECG	4,376.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,158.00	1,413.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,498.50	35,151.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	3,036.00
RESPIRATORY SERVICES	846.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,595.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	5,663.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	35,969.00	1,198.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,006.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,305.22	1,284.12
RADIOLOGY THERAPEUTIC	1,492.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,747.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,940.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,460.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,494.00	994.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,324.00	1,486.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	989.00	2,123.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,107.00	0.00			
			TOTAL ANCILLARY	234,910.53	105,835.62
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	234,910.53	105,835.62

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	799,129.27	ADJUSTMENTS	588.34
COVERED CHARGES	780,179.11	CONTRACTUAL ALLOW	752,432.87
NON-COVERD CHARGES	18,950.16	TOTAL MEDICAID LIAB	27,746.24
		LESS: COB	0.00
		LESS: COPAYMENT	1,176.01
		REIMBURSEMENT	26,570.23
		TOTAL NUMBER OF CLAIMS	496

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,216.00	19.64	OTHER LAB	2,546.00	0.00
MED/SURG SUPPLY	3,335.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	72,093.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	41,070.00	4,802.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	134,357.00	10,886.00
EKG/ECG	10,903.00	0.00	MRI SERVICES	14,595.00	0.00
IV THERAPY	39,217.00	1,696.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,139.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	448,088.00	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	9,620.11	1,404.52
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	142.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	780,179.11	18,950.16
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	780,179.11	18,950.16

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,043.24	ADJUSTMENTS	0.00
COVERED CHARGES	12,006.00	CONTRACTUAL ALLOW	6,335.74
NON-COVERD CHARGES	5,037.24	TOTAL MEDICAID LIAB	5,670.26
		LESS: COB	5,655.26
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	6

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	52.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	63.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,800.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	4,802.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,370.00	0.00
EKG/ECG	408.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	406.00	194.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,907.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	41.24
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	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	12,006.00	5,037.24
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,006.00	5,037.24

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,863,305.66	ADJUSTMENTS	22,175.92
COVERED CHARGES	3,606,486.73	CONTRACTUAL ALLOW	3,251,047.89
NON-COVERD CHARGES	256,818.93	TOTAL MEDICAID LIAB	355,438.84
		LESS: COB	0.00
		LESS: COPAYMENT	378.76
		REIMBURSEMENT	355,060.08
		TOTAL NUMBER OF CLAIMS	64

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,770.15	78.92	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	176,060.50	8,325.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	33,158.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	44,991.00	6,358.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	348.00	FEE SCHEDULE LAB	76,243.00	18,056.00
EKG/ECG	5,711.00	8,381.00	MRI SERVICES	0.00	0.00
IV THERAPY	22,052.00	1,908.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	788,138.50	19,949.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	28,790.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	64,560.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,452.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	78,303.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	151,086.58	6,232.51
RADIOLOGY THERAPEUTIC	7,736.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	626.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	938.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	126.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,576,222.00	25,900.00
LITHOTRIPSY	318,730.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,494.00	994.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,758.00	2,038.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	136,554.00	156,560.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	47,677.00	0.00			
			TOTAL ANCILLARY	3,606,486.73	256,818.93
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,606,486.73	256,818.93

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	314,299.25	ADJUSTMENTS	0.00
COVERED CHARGES	302,809.25	CONTRACTUAL ALLOW	211,229.65
NON-COVERD CHARGES	11,490.00	TOTAL MEDICAID LIAB	91,579.60
		LESS: COB	91,571.81
		LESS: COPAYMENT	7.79
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,588.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,788.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,114.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,050.00	798.00
EKG/ECG	445.00	1,335.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	110,629.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	686.25	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	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	181,509.00	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	9,248.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	302,809.25	11,490.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	302,809.25	11,490.00

ROCKDALE MEDICAL CENTER
 1412 MILSTEAD RD NE
 CONYERS,GA 30012-0000

PROVIDER NUMBER 000001603A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,333,855.75	ADJUSTMENTS	1,987,767.06
COVERED CHARGES	25,490,509.87	CONTRACTUAL ALLOW	18,923,599.92
NON-COVERD CHARGES	843,345.88	TOTAL MEDICAID LIAB	6,566,909.95
		LESS: COB	56,731.62
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,510,178.33

TOTAL NUMBER OF ADMISSIONS 934

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,292		2	1,231,966.00		222,639.00
ROUTINE NURSERY	670		5	1,179,795.40		102,667.80
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,962		7	2,411,761.40		325,306.80
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	845		0	1,111,306.00		8,407.00
NICU	539		0	2,949,899.75		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,384		0	4,061,205.75		8,407.00
TOTAL ACCOMODATIONS	4,346		7	6,472,967.15		333,713.80

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

ROCKDALE MEDICAL CENTER
 1412 MILSTEAD RD NE
 CONYERS,GA 30012-0000

PROVIDER NUMBER
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,223,108.52	5,933.89	OTHER LAB	150,254.15	0.00
MED/SURG SUPPLY	1,212,987.87	23,545.77	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,881,780.74	53,643.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	375,977.00	2,667.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	970,910.00	7,879.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	68,333.38	3,146.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	126,257.25	0.00	MRI SERVICES	159,051.00	0.00
IV THERAPY	302,339.00	4,406.00	PROFESSIONAL FEES	0.00	44.00
OPERATING ROOM	926,864.30	2,306.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,388,980.05	66,647.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,007,798.80	24,083.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	326,976.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	82,939.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	836,163.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	280,364.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	158,394.60	0.00	INJECTABLE DRUGS	1,980,230.62	10,824.42
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	23,631.42	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	15,999.51	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	254,653.91	7,425.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	38,992.00	1,555.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	622,299.00	2,263.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	74,876.00
OTHER IMAGING SERVICE	252,710.00	6,849.00			
BLOOD	5,310.00	0.00			
BLOOD STORAGE & PRO.	481,368.00	196,888.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	87,364.00	14,651.00			
AUDIOLOGY	26,599.95	0.00			
CARDIOLOGY	667,589.95	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	37,774.70	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	43,541.00	0.00			
			TOTAL ANCILLARY	19,017,542.72	509,632.08
			TOTAL ACCOMODATIONS	6,472,967.15	333,713.80
			TOTAL CHARGES	25,490,509.87	843,345.88

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

ROCKDALE MEDICAL CENTER
 1412 MILSTEAD RD NE
 CONYERS,GA 30012-0000

PROVIDER NUMBER
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013297054303	10/11/13 - 10/19/13	10/28/13	0.00	2,287.00	0.00	0.00	0.00
615	2013301024945	10/20/13 - 10/21/13	11/04/13	0.00	4,525.00	0.00	0.00	0.00
614	2013329019543	10/24/13 - 10/27/13	12/02/13	0.00	2,644.00	0.00	0.00	0.00
615	2013337044729	11/16/13 - 11/19/13	12/09/13	0.00	4,525.00	0.00	0.00	0.00
614	2013340095843	11/21/13 - 11/25/13	12/09/13	0.00	2,575.00	0.00	0.00	0.00
614	2013343019371	11/21/13 - 11/27/13	12/16/13	0.00	2,575.00	0.00	0.00	0.00
615	2013347051474	12/02/13 - 12/04/13	12/23/13	0.00	4,525.00	0.00	0.00	0.00
614	2014021021840	12/27/13 - 01/13/14	01/27/14	0.00	2,811.00	0.00	0.00	0.00
615	2014022074565	01/14/14 - 01/16/14	01/27/14	0.00	4,752.00	0.00	0.00	0.00
615	5214050000258	10/06/13 - 10/14/13	02/24/14	0.00	4,525.00	0.00	0.00	0.00
615	2014057047990	01/21/14 - 01/24/14	03/03/14	0.00	4,752.00	0.00	0.00	0.00
614	2014132018798	04/11/14 - 04/15/14	05/19/14	0.00	2,829.00	0.00	0.00	0.00
614	2014136045453	10/24/13 - 10/29/13	05/19/14	0.00	2,694.00	0.00	0.00	0.00
614	2014136045459	05/05/14 - 05/07/14	05/19/14	0.00	2,829.00	0.00	0.00	0.00
614	2014146006126	01/19/14 - 02/15/14	06/02/14	0.00	2,769.00	0.00	0.00	0.00
614	2014258031579	09/03/14 - 09/09/14	09/22/14	0.00	3,699.00	0.00	0.00	0.00
615	2014265028689	09/15/14 - 09/16/14	09/29/14	0.00	2,402.00	0.00	0.00	0.00
614	2014265028907	09/02/14 - 09/15/14	09/29/14	0.00	2,704.00	0.00	0.00	0.00
614	2014275061207	09/20/14 - 09/24/14	10/06/14	0.00	2,775.00	0.00	0.00	0.00
615	5914314004544	12/25/13 - 12/28/13	11/17/14	0.00	4,525.00	0.00	0.00	0.00
615	2015001002666	08/24/14 - 08/26/14	01/05/15	0.00	2,402.00	0.00	0.00	0.00
615	2315100000124	05/12/14 - 05/19/14	05/04/15	0.00	4,752.00	0.00	1,599.79	0.00
TOTAL				0.00	74,876.00	0.00	1,599.79	0.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
 Run Time: 00:25:45
 Page: 4

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

ROCKDALE MEDICAL CENTER
 1412 MILSTEAD RD NE
 CONYERS,GA 30012-0000

PROVIDER NUMBER 000001603A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,010,430.18	ADJUSTMENTS	0.00
COVERED CHARGES	998,001.18	CONTRACTUAL ALLOW	656,957.87
NON-COVERD CHARGES	12,429.00	TOTAL MEDICAID LIAB	341,043.31
		LESS: COB	341,043.31
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 11

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	30		0	16,260.00		1,594.00
ROUTINE NURSERY	3		0	11,508.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	33		0	27,768.00		1,594.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	98		0	537,530.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	98		0	537,530.00		0.00
TOTAL ACCOMODATIONS	131		0	565,298.00		1,594.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

ROCKDALE MEDICAL CENTER
 1412 MILSTEAD RD NE
 CONYERS,GA 30012-0000

PROVIDER NUMBER
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47,737.85	0.00	OTHER LAB	1,396.00	0.00
MED/SURG SUPPLY	49,096.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	121,694.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,820.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	362.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,755.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	66,274.00	4,367.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	79,425.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,358.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,623.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,555.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,794.00	0.00	INJECTABLE DRUGS	12,069.33	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,824.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,064.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,354.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,448.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,926.00	6,468.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	362.00	0.00			
CARDIOLOGY	2,766.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	432,703.18	10,835.00
			TOTAL ACCOMODATIONS	565,298.00	1,594.00
			TOTAL CHARGES	998,001.18	12,429.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
Run Time: 00:25:46
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ROCKDALE MEDICAL CENTER
1412 MILSTEAD RD NE
CONYERS,GA 30012-0000

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,424,162.16	ADJUSTMENTS	235,116.18
COVERED CHARGES	13,751,885.41	CONTRACTUAL ALLOW	11,409,140.74
NON-COVERD CHARGES	1,672,276.75	TOTAL MEDICAID LIAB	2,342,744.67
		LESS: COB	12,852.13
		LESS: COPAYMENT	4,374.00
		REIMBURSEMENT	2,325,518.54
		ALL OTHER	2,113,352.68
		FEE SCHEDULE-LAB	199,683.81
		INJECTABLE DRUGS	12,482.05

TOTAL NUMBER OF CLAIMS 4,915

ROCKDALE MEDICAL CENTER
 1412 MILSTEAD RD NE
 CONYERS,GA 30012-0000

PROVIDER NUMBER
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	252,640.67	49,224.02	OTHER LAB	261,356.40	3,391.00
MED/SURG SUPPLY	445,897.23	18,847.13	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	375.00	EDUCATION & TRAINING	0.00	39.00
RADIOLOGY-DIAGNOSTIC	379,165.00	13,676.80	OTHER THERAPEUTIC SVC	0.00	315.10
CT SCAN	1,832,409.00	174,811.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	48,189.55	9,372.40	FEE SCHEDULE LAB	3,190,232.06	534,895.82
EKG/ECG	193,054.00	6,130.00	MRI SERVICES	386,804.70	31,243.00
IV THERAPY	682,768.95	132,723.85	PROFESSIONAL FEES	0.00	141.00
OPERATING ROOM	695,804.41	141,807.58	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	48,353.00	139,858.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	309,568.00	2,797.00	AMBULANCE	0.00	0.00
GI SERVICES	232,205.88	35,180.87	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,006,297.91	49,858.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	270,058.00	2,136.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	46,178.52	15,773.12
RADIOLOGY THERAPEUTIC	991.85	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,188.00	507.40	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,604.00	1,696.66	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	13,223.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	41,417.00	6,339.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	76,657.18	24,492.00
LITHOTRIPSY	9,378.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	617,280.00	64,699.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	99,907.00	7,494.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	112,293.00	54,167.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	153,941.40	135,813.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	11,498.70	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	343,746.00	1,250.00			
			TOTAL ANCILLARY	13,751,885.41	1,672,276.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,751,885.41	1,672,276.75

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

Run Date: 07/15/2015
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ROCKDALE MEDICAL CENTER
1412 MILSTEAD RD NE
CONYERS,GA 30012-0000

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	352,845.64	ADJUSTMENTS	0.00
COVERED CHARGES	286,330.54	CONTRACTUAL ALLOW	192,673.66
NON-COVERD CHARGES	66,515.10	TOTAL MEDICAID LIAB	93,656.88
		LESS: COB	93,599.88
		LESS: COPAYMENT	57.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 124

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ROCKDALE MEDICAL CENTER
 1412 MILSTEAD RD NE
 CONYERS,GA 30012-0000

PROVIDER NUMBER
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,853.93	114.37	OTHER LAB	3,465.00	686.00
MED/SURG SUPPLY	3,407.50	163.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	34.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,664.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,469.00	27,218.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	90,201.30	12,800.00
EKG/ECG	4,389.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	21,754.00	1,258.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,119.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,037.00	511.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,658.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,988.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	92,556.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,828.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	349.56	7,173.73
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	497.00	92.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	17,507.00	14,321.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,627.00	156.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,698.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,250.00	0.00			
			TOTAL ANCILLARY	286,330.54	66,515.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	286,330.54	66,515.10

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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ROCKDALE MEDICAL CENTER
1412 MILSTEAD RD NE
CONYERS,GA 30012-0000

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	704,211.54	ADJUSTMENTS	809.10
COVERED CHARGES	661,642.04	CONTRACTUAL ALLOW	631,937.90
NON-COVERD CHARGES	42,569.50	TOTAL MEDICAID LIAB	29,704.14
		LESS: COB	165.02
		LESS: COPAYMENT	738.00
		REIMBURSEMENT	28,801.12
		TOTAL NUMBER OF CLAIMS	531

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

ROCKDALE MEDICAL CENTER
 1412 MILSTEAD RD NE
 CONYERS,GA 30012-0000

PROVIDER NUMBER
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,416.00	171.91	OTHER LAB	19,472.00	2,148.00
MED/SURG SUPPLY	5,107.00	634.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,419.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,154.00	4,353.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	197,394.39	26,123.00
EKG/ECG	6,442.50	0.00	MRI SERVICES	3,139.00	0.00
IV THERAPY	22,279.00	1,168.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,502.00	803.25	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	334,477.00	192.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,035.15	100.34
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	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	18,099.00	6,876.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,706.00	0.00			
			TOTAL ANCILLARY	661,642.04	42,569.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	661,642.04	42,569.50

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ROCKDALE MEDICAL CENTER
1412 MILSTEAD RD NE
CONYERS,GA 30012-0000

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	59,004.12	ADJUSTMENTS	0.00
COVERED CHARGES	49,422.99	CONTRACTUAL ALLOW	34,553.57
NON-COVERD CHARGES	9,581.13	TOTAL MEDICAID LIAB	14,869.42
		LESS: COB	14,857.42
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	36

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ROCKDALE MEDICAL CENTER
 1412 MILSTEAD RD NE
 CONYERS,GA 30012-0000

PROVIDER NUMBER
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	456.81	69.31	OTHER LAB	5,758.00	1,047.00
MED/SURG SUPPLY	203.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	352.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	4,212.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	18,200.80	455.00
EKG/ECG	285.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,180.00	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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	17,288.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	51.38	318.82
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,026.00	2,940.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,622.00	227.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	49,422.99	9,581.13
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	49,422.99	9,581.13

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII

Run Date: 07/15/2015
Run Time: 00:26:15
Page: 14

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROCKDALE MEDICAL CENTER
1412 MILSTEAD RD NE
CONYERS,GA 30012-0000

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	405,548.39	ADJUSTMENTS	16,651.95
COVERED CHARGES	293,588.71	CONTRACTUAL ALLOW	255,779.38
NON-COVERD CHARGES	111,959.68	TOTAL MEDICAID LIAB	37,809.33
		LESS: COB	0.00
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	37,782.33
		TOTAL NUMBER OF CLAIMS	7

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROCKDALE MEDICAL CENTER
 1412 MILSTEAD RD NE
 CONYERS,GA 30012-0000

PROVIDER NUMBER
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,843.72	1,114.07	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	53,219.75	92.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,214.00	4,669.00	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	5,276.00	0.00
EKG/ECG	285.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	64,337.35	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,769.00	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	3,063.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	154.89	86.16
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	136,801.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	105,998.45			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,625.00	0.00			
			TOTAL ANCILLARY	293,588.71	111,959.68
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	293,588.71	111,959.68

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROCKDALE MEDICAL CENTER
1412 MILSTEAD RD NE
CONYERS,GA 30012-0000

PROVIDER NUMBER
000001603A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF 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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	39,579,981.62	ADJUSTMENTS	1,231,104.62
COVERED CHARGES	38,531,644.30	CONTRACTUAL ALLOW	32,361,901.01
NON-COVERD CHARGES	1,048,337.32	TOTAL MEDICAID LIAB	6,169,743.29
		LESS: COB	11,632.46
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,158,110.83

TOTAL NUMBER OF ADMISSIONS 764

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,826	21	3,526,718.25	607,288.25
ROUTINE NURSERY	177	2	225,675.00	37,870.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3,003	23	3,752,393.25	645,158.25
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	430	0	1,464,305.00	18,175.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	430	0	1,464,305.00	18,175.00
TOTAL ACCOMODATIONS	3,433	23	5,216,698.25	663,333.25

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,351,923.00	12,957.75	OTHER LAB	163,140.75	0.00
MED/SURG SUPPLY	1,491,238.25	36,241.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,283,149.50	41,857.75	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	702,471.50	2,127.75	OTHER THERAPEUTIC SVC	0.00	1,476.00
CT SCAN	1,996,623.50	31,222.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	257,850.57	3,685.25	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	372,127.75	0.00	MRI SERVICES	607,373.75	0.00
IV THERAPY	43,312.50	4,117.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,198,755.75	30,827.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	642,504.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,726,658.50	25,541.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,033,270.00	10,146.25	AMBULANCE	0.00	0.00
GI SERVICES	228,508.25	7,873.75	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,192,311.00	6,117.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	492,848.25	2,595.25	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	220,423.00	1,401.25	INJECTABLE DRUGS	5,815,656.18	71,061.07
RADIOLOGY THERAPEUTIC	155,248.50	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	90,246.54	1,386.75	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	57,436.75	926.25	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	39,643.50	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,250.50	590.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	256,518.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	248,103.75	15,624.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	130,482.75	51,360.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	442,956.25	10,480.00			
AUDIOLOGY	0.00	12,057.50			
CARDIOLOGY	2,000,851.00	1,975.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	18,952.50	1,353.75			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	47,109.51	0.00			
			TOTAL ANCILLARY	33,314,946.05	385,004.07
			TOTAL ACCOMODATIONS	5,216,698.25	663,333.25
			TOTAL CHARGES	38,531,644.30	1,048,337.32

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	135,043.60	ADJUSTMENTS	0.00
COVERED CHARGES	131,543.10	CONTRACTUAL ALLOW	84,084.21
NON-COVERD CHARGES	3,500.50	TOTAL MEDICAID LIAB	47,458.89
		LESS: COB	47,458.89
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 8

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	15		0	19,125.00		2,700.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	15		0	19,125.00		2,700.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	15		0	19,125.00		2,700.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

CARTERSVILLE MEDICAL CENTER PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
 960 JOE FRANK HARRIS PKWY SE 000001625A SERVICE DATES 10/01/13 THROUGH 09/30/14
 CARTERSVILLE,GA 30120-2129 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,403.00	0.00	OTHER LAB	1,122.50	0.00
MED/SURG SUPPLY	5,806.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,223.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,836.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	138.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,370.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	49,305.75	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,508.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,177.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,289.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,108.00	0.00	INJECTABLE DRUGS	6,803.35	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,325.00	800.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	112,418.10	800.50
			TOTAL ACCOMODATIONS	19,125.00	2,700.00
			TOTAL CHARGES	131,543.10	3,500.50

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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Page: 5

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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,354,553.62	ADJUSTMENTS	123,095.52
COVERED CHARGES	20,032,589.86	CONTRACTUAL ALLOW	17,392,698.79
NON-COVERD CHARGES	2,321,963.76	TOTAL MEDICAID LIAB	2,639,891.07
		LESS: COB	4,023.81
		LESS: COPAYMENT	4,161.02
		REIMBURSEMENT	2,631,706.24
		ALL OTHER	2,421,921.66
		FEE SCHEDULE-LAB	178,280.74
		INJECTABLE DRUGS	31,503.84

TOTAL NUMBER OF CLAIMS 4,554

Report : CLM-0804-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	548,404.75	1,009.75	OTHER LAB	137,090.75	473.00
MED/SURG SUPPLY	561,215.75	28,456.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,003,001.00	12,616.50	OTHER THERAPEUTIC SVC	198.00	0.00
CT SCAN	2,990,403.75	302,867.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	6,316.78	FEE SCHEDULE LAB	4,742,443.87	971,900.85
EKG/ECG	369,619.75	26,058.50	MRI SERVICES	265,071.25	28,630.00
IV THERAPY	412,520.25	82,694.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,236,273.85	315,936.13	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	88,885.25	2,027.25	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	62,248.50	2,787.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,019,997.25	901.50	AMBULANCE	0.00	0.00
GI SERVICES	257,157.51	19,811.99	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,421,402.38	164,833.63	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	639,173.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	341,177.65	92,763.00
RADIOLOGY THERAPEUTIC	411,511.75	1,016.50	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,988.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	752.00	4,282.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,153.50	2,531.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	68,454.00	1,191.00
LITHOTRIPSY	47,905.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	517,482.75	37,105.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	47,766.00	9,606.00			
ONCOLOGY	151.50	0.00			
NUCLEAR MEDICINE	392,276.50	64,312.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	290,648.62	134,708.63			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	43,809.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	110,393.73	4,138.25			
			TOTAL ANCILLARY	20,032,589.86	2,321,963.76
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	20,032,589.86	2,321,963.76

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	372,146.00	ADJUSTMENTS	0.00
COVERED CHARGES	286,736.25	CONTRACTUAL ALLOW	201,947.37
NON-COVERD CHARGES	85,409.75	TOTAL MEDICAID LIAB	84,788.88
		LESS: COB	84,746.88
		LESS: COPAYMENT	42.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 55

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CARTERSVILLE MEDICAL CENTER PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
 960 JOE FRANK HARRIS PKWY SE 000001625A SERVICE DATES 10/01/13 THROUGH 09/30/14
 CARTERSVILLE,GA 30120-2129 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,261.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	19,691.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,372.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	42,348.00	11,142.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	66,676.75	13,384.50
EKG/ECG	6,500.00	0.00	MRI SERVICES	5,599.75	0.00
IV THERAPY	14,115.75	454.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,743.25	54,585.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	923.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	765.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	29,034.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	42,428.75	2,870.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,337.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,868.25	1,850.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	678.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	170.75	75.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,280.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,025.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,550.00	800.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,039.00	247.25			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,326.75	0.00			
			TOTAL ANCILLARY	286,736.25	85,409.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	286,736.25	85,409.75

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,859,949.05	ADJUSTMENTS	1,615.20
COVERED CHARGES	1,753,461.80	CONTRACTUAL ALLOW	1,711,702.06
NON-COVERD CHARGES	106,487.25	TOTAL MEDICAID LIAB	41,759.74
		LESS: COB	0.00
		LESS: COPAYMENT	1,677.00
		REIMBURSEMENT	40,082.74
		TOTAL NUMBER OF CLAIMS	747

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,299.50	5.25	OTHER LAB	8,781.25	0.00
MED/SURG SUPPLY	14,489.00	292.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	112,745.75	420.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	129,164.75	34,412.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	548,661.40	56,478.50
EKG/ECG	20,150.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	40,208.75	2,658.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	821.25	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,224.25	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	786,359.25	2,990.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	31,120.65	7,706.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	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	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	28,436.00	1,374.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,753,461.80	106,487.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,753,461.80	106,487.25

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	536.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	150.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	444.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,634.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,355.25	4,682.00
EKG/ECG	650.00	0.00	MRI SERVICES	9,339.50	0.00
IV THERAPY	441.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	223.50	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	13,346.00	1,062.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	423.50	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	41,544.50	5,744.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	41,544.50	5,744.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
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SUMMARY TYPE VII

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,504,025.19	ADJUSTMENTS	38,404.86
COVERED CHARGES	3,287,402.27	CONTRACTUAL ALLOW	2,862,293.11
NON-COVERD CHARGES	216,622.92	TOTAL MEDICAID LIAB	425,109.16
		LESS: COB	1,640.97
		LESS: COPAYMENT	606.00
		REIMBURSEMENT	422,862.19
		TOTAL NUMBER OF CLAIMS	81

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CARTERSVILLE MEDICAL CENTER PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
 960 JOE FRANK HARRIS PKWY SE 000001625A SERVICE DATES 10/01/13 THROUGH 09/30/14
 CARTERSVILLE,GA 30120-2129 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	96,356.00	193.50	OTHER LAB	1,847.00	0.00
MED/SURG SUPPLY	328,481.00	93.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	24,428.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	67,670.50	4,206.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	731.75	FEE SCHEDULE LAB	144,004.26	30,531.93
EKG/ECG	5,153.50	4,457.00	MRI SERVICES	5,350.25	0.00
IV THERAPY	28,631.75	4,691.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,145,163.88	85,147.62	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,011.50	95.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	513,198.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,402.00	2,293.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	206,464.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	107,648.50	15,479.50
RADIOLOGY THERAPEUTIC	335,033.25	2,733.25	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	999.25	73.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	92,977.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,875.00	2,820.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	19,977.75	1,057.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	79,852.13	62,018.87			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	53,876.75	0.00			
			TOTAL ANCILLARY	3,287,402.27	216,622.92
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,287,402.27	216,622.92

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	43,882.75	ADJUSTMENTS	0.00
COVERED CHARGES	43,882.75	CONTRACTUAL ALLOW	29,381.32
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	14,501.43
		LESS: COB	14,498.43
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0814-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CARTERSVILLE MEDICAL CENTER	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
960 JOE FRANK HARRIS PKWY SE	000001625A	SERVICE DATES	10/01/13	THROUGH	09/30/14
CARTERSVILLE,GA 30120-2129		ADMISSION DATES	00/00/00	THROUGH	00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	811.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	660.00	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	12,531.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,589.00	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	1,291.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	26,000.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	43,882.75	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	43,882.75	0.00

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	134,592,420.04	ADJUSTMENTS	15,813,481.86
COVERED CHARGES	128,809,466.44	CONTRACTUAL ALLOW	80,187,600.85
NON-COVERD CHARGES	5,782,953.60	TOTAL MEDICAID LIAB	48,621,865.59
		LESS: COB	219,647.57
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	48,402,218.02

TOTAL NUMBER OF ADMISSIONS 2,641

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	10,743		24	10,634,580.00		4,357,726.00
ROUTINE NURSERY	446		0	859,452.00		14,164.50
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	11,189		24	11,494,032.00		4,371,890.50
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	935		0	4,593,655.00		0.00
PED ICU	4,142		0	15,609,541.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	5,077		0	20,203,196.00		0.00
TOTAL ACCOMODATIONS	16,266		24	31,697,228.00		4,371,890.50

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,098,720.20	1,004,562.60	OTHER LAB	195,748.00	0.00
MED/SURG SUPPLY	6,910,742.32	55,573.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,241,019.21	54,196.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,518,379.50	0.00	OTHER THERAPEUTIC SVC	11,562.00	109,497.00
CT SCAN	1,323,151.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	504,056.00	166.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	45,461.00	0.00	MRI SERVICES	1,357,593.50	0.00
IV THERAPY	163,823.50	1,166.00	PROFESSIONAL FEES	0.00	11,445.00
OPERATING ROOM	8,102,657.00	7,799.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	17,455,714.00	26,151.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,567,926.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,501.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,781,160.00	31,176.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	831,461.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	609,662.85	23.50	INJECTABLE DRUGS	32,716.86	0.00
RADIOLOGY THERAPEUTIC	103,888.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	205,858.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	227,937.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	11,012.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	924.00	32,847.00	TRAUMA RESPONSE	0.00	32,049.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	8,231,635.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,414.00
OTHER IMAGING SERVICE	272,828.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	608,448.00	27,663.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	110,887.00	2,711.50			
AUDIOLOGY	40,154.50	0.00			
CARDIOLOGY	607,483.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,794,051.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	154,086.50	609.00			
			TOTAL ANCILLARY	97,112,238.44	1,411,063.10
			TOTAL ACCOMODATIONS	31,697,228.00	4,371,890.50
			TOTAL CHARGES	128,809,466.44	5,782,953.60

Report : CLM-0800-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

Run Date: 07/15/2015
Run Time: 00:27:05
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014065045067	01/02/14 - 01/17/14	03/10/14	0.00	603.50	0.00	0.00	0.00
614	2014066050811	02/21/14 - 02/25/14	03/10/14	0.00	603.50	0.00	0.00	0.00
614	2014092046135	03/21/14 - 03/27/14	04/07/14	0.00	603.50	0.00	0.00	0.00
614	2014352030396	12/09/14 - 12/12/14	12/22/14	0.00	603.50	0.00	0.00	0.00
TOTAL				0.00	2,414.00	0.00	0.00	0.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,277,520.80	ADJUSTMENTS	0.00
COVERED CHARGES	6,996,027.30	CONTRACTUAL ALLOW	1,420,702.94
NON-COVERD CHARGES	281,493.50	TOTAL MEDICAID LIAB	5,575,324.36
		LESS: COB	5,575,324.36
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 143

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	471		0	466,290.00		205,972.50
ROUTINE NURSERY	46		0	93,114.00		1,065.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	517		0	559,404.00		207,037.50
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	178		0	874,514.00		0.00
PED ICU	86		0	312,841.50		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	264		0	1,187,355.50		0.00
TOTAL ACCOMODATIONS	781		0	1,746,759.50		207,037.50

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,592,720.05	0.00	OTHER LAB	5,719.00	0.00
MED/SURG SUPPLY	265,569.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	609,273.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	72,663.00	0.00	OTHER THERAPEUTIC SVC	1,756.00	2,885.00
CT SCAN	77,833.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	20,975.50	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,488.00	0.00	MRI SERVICES	85,529.50	0.00
IV THERAPY	5,349.00	0.00	PROFESSIONAL FEES	0.00	66,901.50
OPERATING ROOM	368,209.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	725,875.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	194,956.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	190,789.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	35,017.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	68,647.75	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	47,950.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,224.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	10,955.50	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	2,059.50	TRAUMA RESPONSE	0.00	1,730.50
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	336,054.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,145.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	44,810.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	16,914.50	879.50			
AUDIOLOGY	2,578.00	0.00			
CARDIOLOGY	42,687.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	391,933.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,645.00	0.00			
			TOTAL ANCILLARY	5,249,267.80	74,456.00
			TOTAL ACCOMODATIONS	1,746,759.50	207,037.50
			TOTAL CHARGES	6,996,027.30	281,493.50

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	45,069,948.82	ADJUSTMENTS	3,709,756.45
COVERED CHARGES	42,008,913.32	CONTRACTUAL ALLOW	29,431,811.02
NON-COVERD CHARGES	3,061,035.50	TOTAL MEDICAID LIAB	12,577,102.30
		LESS: COB	43,528.53
		LESS: COPAYMENT	168.00
		REIMBURSEMENT	12,533,405.77
		ALL OTHER	11,191,834.52
		FEE SCHEDULE-LAB	432,577.22
		INJECTABLE DRUGS	908,994.03

TOTAL NUMBER OF CLAIMS 19,786

CHILDREN'S HEALTHCARE OF ATLANTA PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
 1001 JOHNSON FERRY RD NE 000001636A SERVICE DATES 01/01/14 THROUGH 12/31/14
 ATLANTA,GA 30342-1605 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,469,118.50	11,550.75	OTHER LAB	189,922.50	773.00
MED/SURG SUPPLY	2,703,809.75	150.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	249.00	EDUCATION & TRAINING	4,108.00	0.00
RADIOLOGY-DIAGNOSTIC	1,367,259.00	14,437.50	OTHER THERAPEUTIC SVC	156.00	3,038.50
CT SCAN	1,751,579.00	97,793.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,154,495.50	81,085.00	FEE SCHEDULE LAB	5,345,225.23	1,162,672.30
EKG/ECG	24,304.00	410.00	MRI SERVICES	2,752,648.00	121,870.50
IV THERAPY	770,526.00	9,241.50	PROFESSIONAL FEES	0.00	5,541.50
OPERATING ROOM	4,548,078.84	520,196.20	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	244,137.50	35,663.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,839,613.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	198,280.50	27,970.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,772,523.50	52,116.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	775,501.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,331,985.00	577,888.00
RADIOLOGY THERAPEUTIC	376,276.50	10,619.50	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	517,529.00	62,521.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	477,968.50	38,135.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,080,740.50	128,178.00	TRAUMA RESPONSE	0.00	26,913.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	257,418.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	539,952.50	7,088.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	733,891.50	3,825.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	143,348.50	11,844.00			
AUDIOLOGY	234,717.50	14,507.00			
CARDIOLOGY	98,813.50	11,170.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,630,353.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	674,632.00	23,586.00			
			TOTAL ANCILLARY	42,008,913.32	3,061,035.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	42,008,913.32	3,061,035.50

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015099024529	12/11/14 - 12/11/14	04/13/15	0.00	0.00	0.00	0.00	0.00
TOTAL				0.00	0.00	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,490,943.25	ADJUSTMENTS	0.00
COVERED CHARGES	2,183,348.75	CONTRACTUAL ALLOW	288,176.50
NON-COVERD CHARGES	307,594.50	TOTAL MEDICAID LIAB	1,895,172.25
		LESS: COB	1,895,169.25
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 517

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	135,552.50	661.50	OTHER LAB	798.50	0.00
MED/SURG SUPPLY	180,455.25	1,050.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,495.00	745.00	OTHER THERAPEUTIC SVC	0.00	80.50
CT SCAN	57,082.50	11,711.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	54,317.00	4,106.50	FEE SCHEDULE LAB	202,890.00	30,238.50
EKG/ECG	744.00	0.00	MRI SERVICES	272,655.50	28,130.50
IV THERAPY	3,037.50	290.50	PROFESSIONAL FEES	0.00	29,904.00
OPERATING ROOM	387,393.50	59,112.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	19,637.00	2,867.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	278,946.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,930.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	90,457.50	1,899.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	78,104.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	144,290.50	63,034.50
RADIOLOGY THERAPEUTIC	40,357.50	1,630.50	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	23,620.50	4,190.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	21,167.50	2,478.50	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	15,397.00	3,604.50	TRAUMA RESPONSE	0.00	870.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	11,053.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	18,176.00
OTHER IMAGING SERVICE	8,777.00	523.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,112.00	6,515.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	26,693.00	5,077.00			
AUDIOLOGY	13,524.50	1,762.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	57,642.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	22,218.00	28,935.00			
			TOTAL ANCILLARY	2,183,348.75	307,594.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,183,348.75	307,594.50

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014241052859	02/03/14 - 02/03/14	09/01/14	0.00	942.50	0.00	1,472.17	0.00
932	2014241052859	02/04/14 - 02/04/14	09/01/14	0.00	942.50	0.00	1,472.17	0.00
932	2014241052859	02/05/14 - 02/05/14	09/01/14	0.00	1,095.50	0.00	1,472.17	0.00
932	2014241052861	02/07/14 - 02/07/14	09/01/14	0.00	1,274.50	0.00	2,323.35	0.00
932	2014241052861	02/10/14 - 02/10/14	09/01/14	0.00	942.50	0.00	2,323.35	0.00
932	2014241052861	02/17/14 - 02/17/14	09/01/14	0.00	248.00	0.00	2,323.35	0.00
932	2014241052861	02/18/14 - 02/18/14	09/01/14	0.00	1,631.00	0.00	2,323.35	0.00
932	2014288010864	03/20/14 - 03/20/14	10/20/14	0.00	2,758.50	0.00	9,863.68	0.00
932	2014288010864	03/21/14 - 03/21/14	10/20/14	0.00	1,232.50	0.00	9,863.68	0.00
932	2014288010864	03/24/14 - 03/24/14	10/20/14	0.00	1,497.00	0.00	9,863.68	0.00
932	2014288010864	03/25/14 - 03/25/14	10/20/14	0.00	1,250.00	0.00	9,863.68	0.00
932	2014288010864	03/26/14 - 03/26/14	10/20/14	0.00	1,333.00	0.00	9,863.68	0.00
932	2014288010864	03/27/14 - 03/27/14	10/20/14	0.00	1,173.00	0.00	9,863.68	0.00
932	2014288010864	03/28/14 - 03/28/14	10/20/14	0.00	1,855.50	0.00	9,863.68	0.00
TOTAL				0.00	18,176.00	0.00	82,755.67	0.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
Run Time: 00:28:47
Page: 12

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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,284,467.25	ADJUSTMENTS	3,020.73
COVERED CHARGES	1,220,968.25	CONTRACTUAL ALLOW	1,155,630.36
NON-COVERD CHARGES	63,499.00	TOTAL MEDICAID LIAB	65,337.89
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	65,328.89
		TOTAL NUMBER OF CLAIMS	1,168

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45,495.00	129.00	OTHER LAB	5,983.50	0.00
MED/SURG SUPPLY	19,878.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	71,989.00	225.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	36,388.50	11,329.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	741.50	0.00	FEE SCHEDULE LAB	188,444.00	43,196.00
EKG/ECG	1,984.00	0.00	MRI SERVICES	11,951.50	0.00
IV THERAPY	1,022.50	0.00	PROFESSIONAL FEES	0.00	814.50
OPERATING ROOM	22,901.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,607.00	99.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,816.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,321.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	762,835.00	1,011.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	376.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,231.75	981.00
RADIOLOGY THERAPEUTIC	1,643.50	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	206.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	429.50	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	921.50	84.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,004.00	4,120.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,636.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,200.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,390.00	1,080.00			
			TOTAL ANCILLARY	1,220,968.25	63,499.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,220,968.25	63,499.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
Run Time: 00:28:54
Page: 14

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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,164.75	ADJUSTMENTS	0.00
COVERED CHARGES	20,126.25	CONTRACTUAL ALLOW	7,360.28
NON-COVERD CHARGES	4,038.50	TOTAL MEDICAID LIAB	12,765.97
		LESS: COB	12,765.97
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	12

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	333.50	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	894.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,163.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,436.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	3,957.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,993.50	81.50	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	1,305.75	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	20,126.25	4,038.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	20,126.25	4,038.50

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,998,576.25	ADJUSTMENTS	395,015.80
COVERED CHARGES	5,828,921.72	CONTRACTUAL ALLOW	5,123,920.37
NON-COVERD CHARGES	169,654.53	TOTAL MEDICAID LIAB	705,001.35
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	705,001.35
		TOTAL NUMBER OF CLAIMS	79

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	116,319.75	409.25	OTHER LAB	1,200.00	0.00
MED/SURG SUPPLY	610,034.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,515.00	267.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,174.00	4,630.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	902.00	2,296.50	FEE SCHEDULE LAB	38,610.00	11,260.00
EKG/ECG	0.00	0.00	MRI SERVICES	14,844.00	4,048.50
IV THERAPY	7,133.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	729,797.72	126,107.28	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	15,943.00	2,769.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	364,421.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	13,842.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,761.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	58,889.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	393,268.50	3,618.00
RADIOLOGY THERAPEUTIC	8,056.50	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	389.50	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	564.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,321,194.50	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,438.00	598.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	76,322.50	6,336.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	26,865.00	6,750.00			
			TOTAL ANCILLARY	5,828,921.72	169,654.53
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,828,921.72	169,654.53

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
Run Time: 00:29:04
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	268,490.00	ADJUSTMENTS	0.00
COVERED CHARGES	249,821.50	CONTRACTUAL ALLOW	7,699.61
NON-COVERD CHARGES	18,668.50	TOTAL MEDICAID LIAB	242,121.89
		LESS: COB	242,121.89
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
1001 JOHNSON FERRY RD NE	000001636A	SERVICE DATES	01/01/14	THROUGH	12/31/14
ATLANTA,GA 30342-1605		ADMISSION DATES	00/00/00	THROUGH	00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,619.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	34,234.00	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	409.50	1,147.50	FEE SCHEDULE LAB	1,424.50	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	24,510.50	15,704.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,954.50	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	3,934.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	26,629.25	602.00
RADIOLOGY THERAPEUTIC	2,809.50	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	225.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	133,255.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,260.00	990.00			
			TOTAL ANCILLARY	249,821.50	18,668.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	249,821.50	18,668.50

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	308,699.16	ADJUSTMENTS	13,583.39
COVERED CHARGES	175,717.08	CONTRACTUAL ALLOW	78,609.06
NON-COVERD CHARGES	132,982.08	TOTAL MEDICAID LIAB	97,108.02
		LESS: COB	7,045.36
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	90,062.66

TOTAL NUMBER OF ADMISSIONS 21

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	57		0	42,693.00		131,396.68
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	57		0	42,693.00		131,396.68
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	57		0	42,693.00		131,396.68

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	53,986.25	0.00	OTHER LAB	1,408.05	0.00
MED/SURG SUPPLY	15,663.59	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	16,927.56	0.00	EDUCATION & TRAINING	47.72	0.00
RADIOLOGY-DIAGNOSTIC	1,584.80	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,179.60	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,585.99	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,586.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,498.58	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,908.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,660.93	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	6,913.71	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	591.40	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,745.60	1,585.40			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,735.30	0.00			
			TOTAL ANCILLARY	133,024.08	1,585.40
			TOTAL ACCOMODATIONS	42,693.00	131,396.68
			TOTAL CHARGES	175,717.08	132,982.08

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
Run Time: 00:29:16
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	787,843.35	ADJUSTMENTS	15,972.67
COVERED CHARGES	713,814.23	CONTRACTUAL ALLOW	391,994.73
NON-COVERD CHARGES	74,029.12	TOTAL MEDICAID LIAB	321,819.50
		LESS: COB	712.24
		LESS: COPAYMENT	1,902.00
		REIMBURSEMENT	319,205.26
		ALL OTHER	281,420.81
		FEE SCHEDULE-LAB	37,610.75
		INJECTABLE DRUGS	173.70
		TOTAL NUMBER OF CLAIMS	1,127

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	91,667.30	767.30	OTHER LAB	8,958.31	0.00
MED/SURG SUPPLY	14,585.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	47.72	0.00
RADIOLOGY-DIAGNOSTIC	45,071.90	104.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	51,268.05	12,047.20	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,639.63	4,620.37	FEE SCHEDULE LAB	172,735.78	42,172.74
EKG/ECG	18,279.70	344.90	MRI SERVICES	0.00	0.00
IV THERAPY	25,247.54	1,465.81	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	39,851.14	2,992.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	18,473.75	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	161,833.58	5,364.73	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	891.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	261.72	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	825.84	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	26,054.65	2,153.20			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,830.40	1,185.40			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	25,552.14	312.50			
			TOTAL ANCILLARY	713,814.23	74,029.12
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	713,814.23	74,029.12

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
0	2014290056994	09/30/14 - 09/30/14	10/20/14	0.00	0.00	0.00	0.00	0.00
TOTAL				0.00	0.00	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,809.31	ADJUSTMENTS	0.00
COVERED CHARGES	4,637.55	CONTRACTUAL ALLOW	1,888.61
NON-COVERD CHARGES	171.76	TOTAL MEDICAID LIAB	2,748.94
		LESS: COB	2,730.94
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 8

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	86.50	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	690.45	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,409.95	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	572.20	171.76
EKG/ECG	172.45	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	66.90	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	639.10	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	4,637.55	171.76
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,637.55	171.76

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	77,325.19	ADJUSTMENTS	0.00
COVERED CHARGES	75,445.02	CONTRACTUAL ALLOW	67,745.02
NON-COVERD CHARGES	1,880.17	TOTAL MEDICAID LIAB	7,700.00
		LESS: COB	21.09
		LESS: COPAYMENT	327.00
		REIMBURSEMENT	7,351.91
		TOTAL NUMBER OF CLAIMS	154

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,034.65	0.00	OTHER LAB	561.40	0.00
MED/SURG SUPPLY	46.66	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,606.60	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,780.90	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,611.96	1,761.92
EKG/ECG	1,207.15	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,908.77	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	503.30	118.25	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	44,074.83	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	624.10	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,484.70	0.00			
			TOTAL ANCILLARY	75,445.02	1,880.17
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	75,445.02	1,880.17

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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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	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII

Run Date: 07/15/2015
Run Time: 00:29:24
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	58,859.84	ADJUSTMENTS	0.00
COVERED CHARGES	58,395.44	CONTRACTUAL ALLOW	39,073.08
NON-COVERD CHARGES	464.40	TOTAL MEDICAID LIAB	19,322.36
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	19,313.36

TOTAL NUMBER OF CLAIMS 4

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,740.85	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,273.03	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	231.36	12.00
EKG/ECG	0.00	172.45	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	50,898.55	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	251.65	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	279.95
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	58,395.44	464.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	58,395.44	464.40

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
Run Time: 00:29:24
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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	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

EMORY-ADVENTIST HOSPITAL
 3949 S COBB DR SE
 SMYRNA,GA 30080-6342

PROVIDER NUMBER 000001702A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,478,728.54	ADJUSTMENTS	0.00
COVERED CHARGES	1,431,308.19	CONTRACTUAL ALLOW	958,475.29
NON-COVERD CHARGES	47,420.35	TOTAL MEDICAID LIAB	472,832.90
		LESS: COB	4,633.16
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	468,199.74

TOTAL NUMBER OF ADMISSIONS 58

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	221		0	180,557.00		2,549.56
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	221		0	180,557.00		2,549.56
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	58		0	116,296.96		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	116,296.96		0.00
TOTAL ACCOMODATIONS	279		0	296,853.96		2,549.56

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

EMORY-ADVENTIST HOSPITAL
 3949 S COBB DR SE
 SMYRNA,GA 30080-6342

PROVIDER NUMBER
 000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38,839.74	0.00	OTHER LAB	9,683.29	0.00
MED/SURG SUPPLY	25,211.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	246,581.30	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	36,583.51	0.00	OTHER THERAPEUTIC SVC	0.00	313.97
CT SCAN	81,892.64	40,110.52	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,505.81	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	36,610.89	0.00	MRI SERVICES	22,130.65	0.00
IV THERAPY	18,507.99	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	46,102.80	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	153,719.17	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,282.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	26,295.74	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	89,805.43	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	17,289.92	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,730.14	0.00	INJECTABLE DRUGS	145,861.19	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,088.91	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,204.53	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	3,684.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	14,476.99	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,058.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	16,170.54	706.99			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	20,624.85	3,739.31			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	37,825.70	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	686.40	0.00			
			TOTAL ANCILLARY	1,134,454.23	44,870.79
			TOTAL ACCOMODATIONS	296,853.96	2,549.56
			TOTAL CHARGES	1,431,308.19	47,420.35

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EMORY-ADVENTIST HOSPITAL
3949 S COBB DR SE
SMYRNA,GA 30080-6342

PROVIDER NUMBER
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
Run Time: 00:29:32
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EMORY-ADVENTIST HOSPITAL
3949 S COBB DR SE
SMYRNA,GA 30080-6342

PROVIDER NUMBER
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,405,702.73	ADJUSTMENTS	8,765.30
COVERED CHARGES	3,032,176.38	CONTRACTUAL ALLOW	2,421,816.25
NON-COVERD CHARGES	373,526.35	TOTAL MEDICAID LIAB	610,360.13
		LESS: COB	1,556.27
		LESS: COPAYMENT	501.00
		REIMBURSEMENT	608,302.86
		ALL OTHER	558,953.66
		FEE SCHEDULE-LAB	44,407.42
		INJECTABLE DRUGS	4,941.78
		TOTAL NUMBER OF CLAIMS	1,228

EMORY-ADVENTIST HOSPITAL
 3949 S COBB DR SE
 SMYRNA,GA 30080-6342

PROVIDER NUMBER
 000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,607.02	7,874.97	OTHER LAB	24,420.35	0.00
MED/SURG SUPPLY	77,380.21	1,361.05	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	108.36	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	219,480.22	1,118.31	OTHER THERAPEUTIC SVC	0.00	12,019.67
CT SCAN	359,455.95	109,905.45	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,898.31	1,353.95	FEE SCHEDULE LAB	471,388.19	63,055.68
EKG/ECG	41,667.62	1,862.24	MRI SERVICES	50,420.82	30,818.48
IV THERAPY	75,410.56	896.90	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	83,733.82	17,837.16	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	19,808.83	2,402.53	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	62,503.11	339.31	AMBULANCE	0.00	0.00
GI SERVICES	56,432.42	13,147.87	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,077,492.05	16,807.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	45,171.46	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,231.89	13,003.43
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	205.18	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,076.55	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	350.00	0.00	IMPL DEV CHARGE PATIENTS	13,045.63	2,979.21
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	95,141.66	19,748.73			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,307.21	2,120.97			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	84,810.65	46,580.38			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	40,536.90	7,107.40			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	47,626.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	44,650.32	0.00			
			TOTAL ANCILLARY	3,032,176.38	373,526.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,032,176.38	373,526.35

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY-ADVENTIST HOSPITAL
3949 S COBB DR SE
SMYRNA,GA 30080-6342

PROVIDER NUMBER
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	79,510.15	ADJUSTMENTS	0.00
COVERED CHARGES	58,875.21	CONTRACTUAL ALLOW	22,101.44
NON-COVERD CHARGES	20,634.94	TOTAL MEDICAID LIAB	36,773.77
		LESS: COB	36,770.07
		LESS: COPAYMENT	3.70
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 31

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY-ADVENTIST HOSPITAL
 3949 S COBB DR SE
 SMYRNA,GA 30080-6342

PROVIDER NUMBER
 000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	369.88	1,078.12	OTHER LAB	650.24	0.00
MED/SURG SUPPLY	471.59	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,533.06	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,215.98	14,799.15	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,594.64	2,127.06
EKG/ECG	1,163.90	0.00	MRI SERVICES	3,535.33	0.00
IV THERAPY	2,607.64	96.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	733.20	92.13	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	31,345.42	1,453.60	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	521.77	377.26
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	611.62			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,132.56	0.00			
			TOTAL ANCILLARY	58,875.21	20,634.94
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	58,875.21	20,634.94

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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EMORY-ADVENTIST HOSPITAL
3949 S COBB DR SE
SMYRNA,GA 30080-6342

PROVIDER NUMBER
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	431,149.18	ADJUSTMENTS	164.82
COVERED CHARGES	401,329.47	CONTRACTUAL ALLOW	383,876.19
NON-COVERD CHARGES	29,819.71	TOTAL MEDICAID LIAB	17,453.28
		LESS: COB	0.00
		LESS: COPAYMENT	525.00
		REIMBURSEMENT	16,928.28
		TOTAL NUMBER OF CLAIMS	312

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY-ADVENTIST HOSPITAL
 3949 S COBB DR SE
 SMYRNA,GA 30080-6342

PROVIDER NUMBER
 000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	311.35	75.00	OTHER LAB	8,448.35	0.00
MED/SURG SUPPLY	1,774.75	258.76	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,593.27	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,129.99	7,256.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	70,262.95	9,785.44
EKG/ECG	5,121.16	0.00	MRI SERVICES	0.00	3,042.51
IV THERAPY	8,022.23	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	1,558.58	184.26	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	250,628.17	177.72	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	333.36	567.17
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	69.61	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	21,051.79	8,403.24			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,093.52	0.00			
			TOTAL ANCILLARY	401,329.47	29,819.71
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	401,329.47	29,819.71

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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EMORY-ADVENTIST HOSPITAL
3949 S COBB DR SE
SMYRNA,GA 30080-6342

PROVIDER NUMBER
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,410.74	ADJUSTMENTS	0.00
COVERED CHARGES	2,871.55	CONTRACTUAL ALLOW	1,983.44
NON-COVERD CHARGES	539.19	TOTAL MEDICAID LIAB	888.11
		LESS: COB	888.11
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY-ADVENTIST HOSPITAL
 3949 S COBB DR SE
 SMYRNA,GA 30080-6342

PROVIDER NUMBER
 000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	73.55	15.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	12.94	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	524.19
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	139.80	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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,627.89	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17.37	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,871.55	539.19
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,871.55	539.19

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY-ADVENTIST HOSPITAL
3949 S COBB DR SE
SMYRNA,GA 30080-6342

PROVIDER NUMBER
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	84,006.04	ADJUSTMENTS	0.00
COVERED CHARGES	79,335.61	CONTRACTUAL ALLOW	62,596.48
NON-COVERD CHARGES	4,670.43	TOTAL MEDICAID LIAB	16,739.13
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	16,724.13

TOTAL NUMBER OF CLAIMS 3

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY-ADVENTIST HOSPITAL
 3949 S COBB DR SE
 SMYRNA,GA 30080-6342

PROVIDER NUMBER
 000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,530.00	15.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,140.54	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,170.63	591.90
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	64,560.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	108.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,826.44	4,063.53
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	79,335.61	4,670.43
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	79,335.61	4,670.43

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY-ADVENTIST HOSPITAL
3949 S COBB DR SE
SMYRNA,GA 30080-6342

PROVIDER NUMBER
000001702A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	30,422,915.23	ADJUSTMENTS	1,885,686.30
COVERED CHARGES	29,368,701.23	CONTRACTUAL ALLOW	19,485,175.68
NON-COVERD CHARGES	1,054,214.00	TOTAL MEDICAID LIAB	9,883,525.55
		LESS: COB	64,298.76
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,819,226.79
		TOTAL NUMBER OF ADMISSIONS	1,210

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	4,505		0	2,825,410.00		472,589.50
ROUTINE NURSERY	331		0	231,136.50		240.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	4,836		0	3,056,546.50		472,829.50
SPECIAL CARE SERVICES						
CCU	257		0	398,350.00		0.00
ICU	690		0	1,069,810.00		0.00
NICU	88		0	123,200.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,035		0	1,591,360.00		0.00
TOTAL ACCOMODATIONS	5,871		0	4,647,906.50		472,829.50

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,361,372.05	20,718.75	OTHER LAB	124,129.25	0.00
MED/SURG SUPPLY	3,064,194.93	103,889.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,765,089.50	14,084.00	EDUCATION & TRAINING	13,640.25	1,200.50
RADIOLOGY-DIAGNOSTIC	327,965.00	166.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,253,128.50	7,974.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	171,908.50	5,791.25	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	260,762.25	157.25	MRI SERVICES	318,308.00	0.00
IV THERAPY	475,312.00	7,134.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,001,206.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	197,074.25	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,367,818.00	3,966.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	244,262.75	259.25	AMBULANCE	0.00	0.00
GI SERVICES	2,142.50	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	573,487.25	2,570.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	235,404.75	2,486.75	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	87,241.50	1,187.75	INJECTABLE DRUGS	1,957,279.25	4,598.25
RADIOLOGY THERAPEUTIC	52,293.75	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	48,116.25	1,995.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	58,212.50	442.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	173,136.00	4,508.75	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	29,427.00	1,513.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,298,978.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	3,783.00
OTHER IMAGING SERVICE	125,895.00	25,489.75			
BLOOD	318,682.25	58,825.50			
BLOOD STORAGE & PRO.	32,996.00	290,946.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	67,753.25	98.75			
AUDIOLOGY	29,024.75	0.00			
CARDIOLOGY	885,823.25	521.25			
AMBULATORY SURGERY	226,535.75	9,290.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	27,709.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	544,484.25	7,785.50			
			TOTAL ANCILLARY	24,720,794.73	581,384.50
			TOTAL ACCOMODATIONS	4,647,906.50	472,829.50
			TOTAL CHARGES	29,368,701.23	1,054,214.00

Report : CLM-0800-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

Run Date: 07/15/2015
Run Time: 00:29:46
Page: 3

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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014174024436	05/18/14 - 05/20/14	06/30/14	0.00	1,891.50	0.00	0.00	0.00
615	9114300009653	06/05/14 - 06/19/14	11/10/14	0.00	1,891.50	0.00	2,804.31	0.00
TOTAL				0.00	3,783.00	0.00	2,804.31	0.00

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	188,912.50	ADJUSTMENTS	0.00
COVERED CHARGES	186,114.50	CONTRACTUAL ALLOW	100,190.36
NON-COVERD CHARGES	2,798.00	TOTAL MEDICAID LIAB	85,924.14
		LESS: COB	85,924.14
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 10

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	23		0	14,490.00		1,690.00
ROUTINE NURSERY	2		0	1,160.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	25		0	15,650.00		1,690.00
SPECIAL CARE SERVICES						
CCU	2		0	3,100.00		0.00
ICU	3		0	4,650.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	5		0	7,750.00		0.00
TOTAL ACCOMODATIONS	30		0	23,400.00		1,690.00

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,129.00	0.00	OTHER LAB	809.25	0.00
MED/SURG SUPPLY	12,923.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,774.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,496.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,622.75	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,415.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	621.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,816.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,594.75	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,805.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,787.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,558.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,557.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	785.50	0.00	INJECTABLE DRUGS	8,712.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	314.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	17,297.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	648.00	0.00			
BLOOD	828.00	0.00			
BLOOD STORAGE & PRO.	46.00	1,108.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	12,651.50	0.00			
AMBULATORY SURGERY	1,431.25	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,089.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,000.00	0.00			
			TOTAL ANCILLARY	162,714.50	1,108.00
			TOTAL ACCOMODATIONS	23,400.00	1,690.00
			TOTAL CHARGES	186,114.50	2,798.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
Run Time: 00:29:57
Page: 6

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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,743,329.51	ADJUSTMENTS	547,729.67
COVERED CHARGES	17,844,502.99	CONTRACTUAL ALLOW	13,270,663.44
NON-COVERD CHARGES	1,898,826.52	TOTAL MEDICAID LIAB	4,573,839.55
		LESS: COB	4,988.89
		LESS: COPAYMENT	12,351.41
		REIMBURSEMENT	4,556,499.25
		ALL OTHER	3,747,472.58
		FEE SCHEDULE-LAB	318,523.49
		INJECTABLE DRUGS	490,503.18
		TOTAL NUMBER OF CLAIMS	9,573

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,057,966.75	1,720.75	OTHER LAB	112,459.00	704.50
MED/SURG SUPPLY	1,063,310.25	16,987.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	683.75	EDUCATION & TRAINING	296.00	824.75
RADIOLOGY-DIAGNOSTIC	547,965.75	13,521.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,823,914.25	231,870.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	309.75	2,919.50	FEE SCHEDULE LAB	1,677,663.69	454,622.34
EKG/ECG	170,742.75	5,503.75	MRI SERVICES	260,506.50	24,794.25
IV THERAPY	1,036,160.00	26,486.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	719,177.57	170,322.43	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	103,331.75	14,169.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	377,922.50	2,343.75	AMBULANCE	0.00	0.00
GI SERVICES	1,024.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,472,332.00	7,928.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	675,944.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,123,630.25	409,878.00
RADIOLOGY THERAPEUTIC	469,152.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	571.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,845.00	4,530.25	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	67,911.00	5,612.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	101,742.50	146,762.00
LITHOTRIPSY	187,551.00	0.00	NO CC/INVALID REV CODE	0.00	157.25
OTHER IMAGING SERVICE	494,202.50	52,950.50			
BLOOD	69,835.75	0.00			
BLOOD STORAGE & PRO.	4,228.50	61,624.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	130,849.25	0.00			
AUDIOLOGY	0.00	473.75			
CARDIOLOGY	233,757.75	130,943.75			
AMBULATORY SURGERY	198,252.23	62,489.25			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	66,308.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	593,210.50	47,430.50			
			TOTAL ANCILLARY	17,844,502.99	1,898,826.52
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,844,502.99	1,898,826.52

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
Run Time: 00:29:57
Page: 8

SOUTH GEORGIA MEDICAL CENTER
2501 N PATTERSON ST
VALDOSTA,GA 31602-1735

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
7301	5914276000122	08/28/14 - 08/28/14	10/06/14	0.00	157.25	0.00	0.00	0.00
TOTAL				0.00	157.25	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

Run Date: 07/15/2015
Run Time: 00:30:41
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	391,578.00	ADJUSTMENTS	0.00
COVERED CHARGES	257,164.50	CONTRACTUAL ALLOW	34,706.48
NON-COVERD CHARGES	134,413.50	TOTAL MEDICAID LIAB	222,458.02
		LESS: COB	222,344.02
		LESS: COPAYMENT	114.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 180

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,781.50	35.50	OTHER LAB	3,843.00	0.00
MED/SURG SUPPLY	21,529.50	76.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	33.75	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,700.50	369.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,210.00	28,337.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	35,841.00	7,098.00
EKG/ECG	3,815.75	0.00	MRI SERVICES	4,082.75	2,986.75
IV THERAPY	7,405.75	185.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,608.50	13,687.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,998.75	372.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,344.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,930.50	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	34,736.25	954.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	26,278.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,425.00	52,903.75
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	80.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	129.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,871.25	12,125.00			
BLOOD	1,420.50	0.00			
BLOOD STORAGE & PRO.	69.00	1,672.25			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,475.50	6,395.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,717.00	4,471.00			
AMBULATORY SURGERY	4,516.25	1,585.75			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	459.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,974.25	1,045.00			
			TOTAL ANCILLARY	257,164.50	134,413.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	257,164.50	134,413.50

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
Run Time: 00:30:44
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	219,366.75	ADJUSTMENTS	429.52
COVERED CHARGES	208,773.25	CONTRACTUAL ALLOW	188,746.73
NON-COVERD CHARGES	10,593.50	TOTAL MEDICAID LIAB	20,026.52
		LESS: COB	0.00
		LESS: COPAYMENT	729.01
		REIMBURSEMENT	19,297.51
		TOTAL NUMBER OF CLAIMS	358

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,953.25	0.00	OTHER LAB	2,237.25	0.00
MED/SURG SUPPLY	8,529.75	254.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,832.25	194.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,096.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,677.00	5,928.75
EKG/ECG	2,201.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,549.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,503.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	662.50	72.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	558.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	89,440.50	267.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,176.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,010.75	116.25
RADIOLOGY THERAPEUTIC	16,541.75	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	80.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,060.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,556.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	3,679.25			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	188.25	0.00			
			TOTAL ANCILLARY	208,773.25	10,593.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	208,773.25	10,593.50

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,565.25	ADJUSTMENTS	0.00
COVERED CHARGES	20,088.00	CONTRACTUAL ALLOW	12,891.14
NON-COVERD CHARGES	1,477.25	TOTAL MEDICAID LIAB	7,196.86
		LESS: COB	7,172.86
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	17

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	976.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,093.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	766.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,927.75	1,041.50
EKG/ECG	634.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,799.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,109.25	92.50	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	536.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,245.50	343.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	20,088.00	1,477.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	20,088.00	1,477.25

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,679,567.50	ADJUSTMENTS	30,120.04
COVERED CHARGES	2,526,407.50	CONTRACTUAL ALLOW	2,100,131.34
NON-COVERD CHARGES	153,160.00	TOTAL MEDICAID LIAB	426,276.16
		LESS: COB	0.00
		LESS: COPAYMENT	930.00
		REIMBURSEMENT	425,346.16
		TOTAL NUMBER OF CLAIMS	78

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	968,783.00	0.00	OTHER LAB	891.00	0.00
MED/SURG SUPPLY	60,315.25	1,097.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,498.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	31,328.50	1,525.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	16,150.25	3,060.75
EKG/ECG	2,201.50	629.00	MRI SERVICES	0.00	0.00
IV THERAPY	99,300.75	90.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	46,451.75	4,713.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,995.75	243.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,407.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	782.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	28,838.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	632,596.25	51,125.25
RADIOLOGY THERAPEUTIC	181,415.75	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	78.00	78.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	314,957.25	24,374.00
LITHOTRIPSY	40,189.50	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,234.25	0.00			
BLOOD	7,866.25	0.00			
BLOOD STORAGE & PRO.	368.00	5,417.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,972.50	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,248.50	51,850.75			
AMBULATORY SURGERY	0.00	8,053.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	43,537.50	901.75			
			TOTAL ANCILLARY	2,526,407.50	153,160.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,526,407.50	153,160.00

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
Run Time: 00:30:51
Page: 17

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	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
 Run Time: 00:31:00
 Page: 1

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,874,151.13	ADJUSTMENTS	168,573.73
COVERED CHARGES	1,807,927.38	CONTRACTUAL ALLOW	981,169.84
NON-COVERD CHARGES	66,223.75	TOTAL MEDICAID LIAB	826,757.54
		LESS: COB	1,502.39
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	825,255.15

TOTAL NUMBER OF ADMISSIONS 180

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	369		0	226,110.00		42,131.75
ROUTINE NURSERY	128		0	75,260.00		1,920.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	497		0	301,370.00		44,051.75
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	15		0	23,250.00		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	15		0	23,250.00		0.00
TOTAL ACCOMODATIONS	512		0	324,620.00		44,051.75

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	231,198.25	46.00	OTHER LAB	4,560.25	0.00
MED/SURG SUPPLY	187,371.25	1,157.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	220,448.13	100.00	EDUCATION & TRAINING	1,228.75	0.00
RADIOLOGY-DIAGNOSTIC	19,134.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	73,851.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,198.25	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,812.50	0.00	MRI SERVICES	4,611.25	0.00
IV THERAPY	6,719.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	114,699.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	58,483.25	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	56,511.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	37,561.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	50,490.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	27,833.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	15,320.75	0.00	INJECTABLE DRUGS	210,552.50	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	4,758.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	37,292.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,162.75	0.00			
BLOOD	13,253.00	0.00			
BLOOD STORAGE & PRO.	1,564.00	20,042.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,475.50	826.50			
AUDIOLOGY	8,328.25	0.00			
CARDIOLOGY	14,252.25	0.00			
AMBULATORY SURGERY	12,523.75	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	46,112.25	0.00			
			TOTAL ANCILLARY	1,483,307.38	22,172.00
			TOTAL ACCOMODATIONS	324,620.00	44,051.75
			TOTAL CHARGES	1,807,927.38	66,223.75

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	44,271.50	ADJUSTMENTS	0.00
COVERED CHARGES	42,718.75	CONTRACTUAL ALLOW	13,616.27
NON-COVERD CHARGES	1,552.75	TOTAL MEDICAID LIAB	29,102.48
		LESS: COB	29,102.48
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7		0	4,320.00		580.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	7		0	4,320.00		580.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	7		0	4,320.00		580.00

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,968.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,133.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,913.25	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	207.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,472.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	157.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	340.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,411.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,165.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,310.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,533.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	890.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	209.50	0.00	INJECTABLE DRUGS	1,573.50	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	1,116.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,070.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	874.00	972.75			
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	1,053.00	0.00			
			TOTAL ANCILLARY	38,398.75	972.75
			TOTAL ACCOMODATIONS	4,320.00	580.00
			TOTAL CHARGES	42,718.75	1,552.75

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,037,676.96	ADJUSTMENTS	116,092.65
COVERED CHARGES	2,708,084.20	CONTRACTUAL ALLOW	1,973,321.13
NON-COVERD CHARGES	329,592.76	TOTAL MEDICAID LIAB	734,763.07
		LESS: COB	46.00
		LESS: COPAYMENT	1,761.00
		REIMBURSEMENT	732,956.07
		ALL OTHER	679,575.36
		FEE SCHEDULE-LAB	50,938.71
		INJECTABLE DRUGS	2,442.00
		TOTAL NUMBER OF CLAIMS	2,010

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	172,787.75	3,925.25	OTHER LAB	14,531.50	0.00
MED/SURG SUPPLY	185,243.25	563.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	411.25	0.00
RADIOLOGY-DIAGNOSTIC	122,032.75	1,775.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	155,121.00	62,432.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	282.75	4,511.00	FEE SCHEDULE LAB	286,515.50	42,292.25
EKG/ECG	22,164.25	314.50	MRI SERVICES	35,124.25	4,977.50
IV THERAPY	141,851.75	8,588.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	349,906.42	117,237.53	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,900.50	891.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	197,033.25	2,851.75	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	364,312.25	2,194.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	216,985.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	64,601.75	6,600.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	407.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	43.00	797.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	38,681.00	4,725.00
LITHOTRIPSY	53,586.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	72,318.25	13,491.50			
BLOOD	828.00	0.00			
BLOOD STORAGE & PRO.	483.00	1,549.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	10,813.50	0.00			
AMBULATORY SURGERY	67,403.28	49,466.73			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	46,601.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	80,521.25	0.00			
			TOTAL ANCILLARY	2,708,084.20	329,592.76
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,708,084.20	329,592.76

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	43,265.75	ADJUSTMENTS	0.00
COVERED CHARGES	36,290.50	CONTRACTUAL ALLOW	7,729.94
NON-COVERD CHARGES	6,975.25	TOTAL MEDICAID LIAB	28,560.56
		LESS: COB	28,557.56
		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

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,866.00	811.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,141.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	141.75	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	366.00	FEE SCHEDULE LAB	2,128.00	133.00
EKG/ECG	571.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,537.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	166.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,137.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,501.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,476.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	154.00	INJECTABLE DRUGS	965.50	1,059.50
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	33.75	4,451.75
LITHOTRIPTY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	435.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	188.25	0.00			
			TOTAL ANCILLARY	36,290.50	6,975.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	36,290.50	6,975.25

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	82,134.00	ADJUSTMENTS	806.10
COVERED CHARGES	79,991.50	CONTRACTUAL ALLOW	70,985.16
NON-COVERD CHARGES	2,142.50	TOTAL MEDICAID LIAB	9,006.34
		LESS: COB	0.00
		LESS: COPAYMENT	399.00
		REIMBURSEMENT	8,607.34
		TOTAL NUMBER OF CLAIMS	161

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,996.00	0.00	OTHER LAB	3,138.50	0.00
MED/SURG SUPPLY	1,630.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,619.00	190.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,472.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,010.00	1,027.00
EKG/ECG	314.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,926.50	925.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	41,350.50	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	3,554.75	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	3,979.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	999.00	0.00			
			TOTAL ANCILLARY	79,991.50	2,142.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	79,991.50	2,142.50

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
Run Time: 00:31:10
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,508.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,334.25	CONTRACTUAL ALLOW	1,293.69
NON-COVERD CHARGES	173.75	TOTAL MEDICAID LIAB	2,040.56
		LESS: COB	2,034.56
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	294.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	154.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	207.50	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	558.00	147.50
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	72.75	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	1,995.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	52.50	26.25
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	3,334.25	173.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,334.25	173.75

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	40,368.50	ADJUSTMENTS	0.00
COVERED CHARGES	37,903.25	CONTRACTUAL ALLOW	27,726.25
NON-COVERD CHARGES	2,465.25	TOTAL MEDICAID LIAB	10,177.00
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	10,171.00
		TOTAL NUMBER OF CLAIMS	2

Report : CLM-0812-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,075.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,117.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	166.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	388.25	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,072.00	2,465.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,992.00	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	5,079.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	143.25	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	473.50	0.00
LITHOTRIPSY	13,396.50	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	37,903.25	2,465.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	37,903.25	2,465.25

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
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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	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

ST FRANCIS HOSPITAL, INC
 2122 MANCHESTER EXPY
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER 000001768A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,534,790.13	ADJUSTMENTS	92,843.12
COVERED CHARGES	16,545,826.63	CONTRACTUAL ALLOW	9,621,622.24
NON-COVERD CHARGES	1,988,963.50	TOTAL MEDICAID LIAB	6,924,204.39
		LESS: COB	64,537.16
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,859,667.23

TOTAL NUMBER OF ADMISSIONS 1,071

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	6,588		0	3,886,920.00		1,959,850.00
ROUTINE NURSERY	135		0	74,250.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	6,723		0	3,961,170.00		1,959,850.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	351		0	465,075.00		0.00
NICU	1		0	2,650.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	352		0	467,725.00		0.00
TOTAL ACCOMODATIONS	7,075		0	4,428,895.00		1,959,850.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

ST FRANCIS HOSPITAL, INC
 2122 MANCHESTER EXPY
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,725,102.46	0.00	OTHER LAB	33,840.00	0.00
MED/SURG SUPPLY	1,111,856.26	1,379.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,259,287.58	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	226,764.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	377,727.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	147,279.47	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	134,213.00	0.00	MRI SERVICES	144,421.00	579.50
IV THERAPY	71,775.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,160,872.75	14,827.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	240,969.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	523,526.85	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	305,996.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	104,620.75	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	453,507.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	76,467.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	143,419.25	0.00	INJECTABLE DRUGS	15,395.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	62,166.79	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	22,073.78	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	54,470.75	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	38.00	2,779.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,111,332.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	37,743.50	0.00			
BLOOD	9,583.00	0.00			
BLOOD STORAGE & PRO.	119,706.25	3,669.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	18,078.75	5,878.00			
AUDIOLOGY	23,851.00	0.00			
CARDIOLOGY	307,315.25	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	22,495.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	71,034.69	0.00			
			TOTAL ANCILLARY	12,116,931.63	29,113.50
			TOTAL ACCOMODATIONS	4,428,895.00	1,959,850.00
			TOTAL CHARGES	16,545,826.63	1,988,963.50

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

ST FRANCIS HOSPITAL, INC
 2122 MANCHESTER EXPY
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER 000001768A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	36,341.86	ADJUSTMENTS	0.00
COVERED CHARGES	31,396.86	CONTRACTUAL ALLOW	11,210.65
NON-COVERD CHARGES	4,945.00	TOTAL MEDICAID LIAB	20,186.21
		LESS: COB	20,186.21
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	14		0	8,260.00		4,945.00
ROUTINE NURSERY	3		0	1,650.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	17		0	9,910.00		4,945.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	17		0	9,910.00		4,945.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

ST FRANCIS HOSPITAL, INC
 2122 MANCHESTER EXPY
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,071.11	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,313.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,810.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,603.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,290.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	841.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	460.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	476.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	231.50	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	391.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	21,486.86	0.00
			TOTAL ACCOMODATIONS	9,910.00	4,945.00
			TOTAL CHARGES	31,396.86	4,945.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
Run Time: 00:31:25
Page: 5

ST FRANCIS HOSPITAL, INC
2122 MANCHESTER EXPY
COLUMBUS,GA 31904-6878

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,104,521.60	ADJUSTMENTS	181,540.14
COVERED CHARGES	7,465,376.54	CONTRACTUAL ALLOW	5,773,946.24
NON-COVERD CHARGES	639,145.06	TOTAL MEDICAID LIAB	1,691,430.30
		LESS: COB	7,451.47
		LESS: COPAYMENT	6,355.08
		REIMBURSEMENT	1,677,623.75
		ALL OTHER	1,504,835.14
		FEE SCHEDULE-LAB	170,878.52
		INJECTABLE DRUGS	1,910.09

TOTAL NUMBER OF CLAIMS 4,848

ST FRANCIS HOSPITAL, INC
 2122 MANCHESTER EXPY
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	414,542.84	835.51	OTHER LAB	28,782.25	0.00
MED/SURG SUPPLY	588,945.76	837.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	284.25	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	321,260.25	7,227.50	OTHER THERAPEUTIC SVC	0.00	342.75
CT SCAN	522,453.50	46,561.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	78,467.00	24,019.19	FEE SCHEDULE LAB	1,373,014.93	181,748.56
EKG/ECG	148,459.75	2,915.00	MRI SERVICES	170,897.75	12,402.00
IV THERAPY	105,314.25	6,354.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	976,379.71	133,338.54	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	66,374.50	10,987.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	262,377.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	94,231.63	19,222.37	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,311,315.75	42,877.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	97,209.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	983.25
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,742.25	9,369.95
RADIOLOGY THERAPEUTIC	365.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	16,458.25	6,501.07	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,067.25	6,197.86	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	5,223.25	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	38,228.00	2,139.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,664.00	3,744.00	IMPL DEV CHARGE PATIENTS	95,280.25	3,217.75
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	165,414.75	14,570.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,844.00	2,705.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	105,599.00	43,200.75			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	325,755.50	47,715.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	77,045.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	55,887.17	3,624.01			
			TOTAL ANCILLARY	7,465,376.54	639,145.06
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,465,376.54	639,145.06

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ST FRANCIS HOSPITAL, INC
2122 MANCHESTER EXPY
COLUMBUS,GA 31904-6878

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	196,636.57	ADJUSTMENTS	0.00
COVERED CHARGES	133,524.71	CONTRACTUAL ALLOW	63,228.05
NON-COVERD CHARGES	63,111.86	TOTAL MEDICAID LIAB	70,296.66
		LESS: COB	70,203.38
		LESS: COPAYMENT	93.28
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 93

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ST FRANCIS HOSPITAL, INC
 2122 MANCHESTER EXPY
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,304.53	220.14	OTHER LAB	428.00	0.00
MED/SURG SUPPLY	15,197.00	642.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,032.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,403.75	12,341.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	28,072.35	1,939.60
EKG/ECG	3,206.50	728.75	MRI SERVICES	0.00	0.00
IV THERAPY	2,106.00	529.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,565.12	29,862.63	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	119.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,227.00	650.00	AMBULANCE	0.00	0.00
GI SERVICES	984.88	3,226.37	CAST ROOM	0.00	0.00
EMERGENCY ROOM	24,443.25	541.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,431.75	914.25	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	919.35	509.70
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	422.25	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	274.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,890.50	1,300.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,126.50	2,071.75			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	6,815.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	572.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	219.73	395.17			
			TOTAL ANCILLARY	133,524.71	63,111.86
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	133,524.71	63,111.86

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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ST FRANCIS HOSPITAL, INC
2122 MANCHESTER EXPY
COLUMBUS,GA 31904-6878

PROVIDER NUMBER 000001768A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	351,287.97	ADJUSTMENTS	756.16
COVERED CHARGES	343,134.58	CONTRACTUAL ALLOW	314,605.18
NON-COVERD CHARGES	8,153.39	TOTAL MEDICAID LIAB	28,529.40
		LESS: COB	101.28
		LESS: COPAYMENT	1,050.00
		REIMBURSEMENT	27,378.12
		TOTAL NUMBER OF CLAIMS	510

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

ST FRANCIS HOSPITAL, INC
 2122 MANCHESTER EXPY
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,191.18	22.00	OTHER LAB	373.00	0.00
MED/SURG SUPPLY	7,273.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,784.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,485.25	1,053.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	95,728.25	3,860.25
EKG/ECG	6,413.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,512.00	264.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,077.75	191.25	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	172,609.25	2,439.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	340.00	3.14
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	3,732.75	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	614.90	0.00			
			TOTAL ANCILLARY	343,134.58	8,153.39
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	343,134.58	8,153.39

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ST FRANCIS HOSPITAL, INC
 2122 MANCHESTER EXPY
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	46.99	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	214.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	414.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,422.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,127.50	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	45.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,366.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	605.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	8,819.24	1,422.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,819.24	1,422.50

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST FRANCIS HOSPITAL, INC
 2122 MANCHESTER EXPY
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,562.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	110,669.67	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,133.25	200.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,422.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	16,937.15	4,920.55
EKG/ECG	1,457.50	1,749.00	MRI SERVICES	0.00	0.00
IV THERAPY	377.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	416,849.03	33,459.72	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	50,720.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,724.25	700.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,265.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,096.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	295.28	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	623,308.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	607.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,384.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	177,752.25	35,872.25			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,692.45	634.25			
			TOTAL ANCILLARY	1,475,959.00	77,831.55
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,475,959.00	77,831.55

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST FRANCIS HOSPITAL, INC
2122 MANCHESTER EXPY
COLUMBUS,GA 31904-6878

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	55,730.19	ADJUSTMENTS	0.00
COVERED CHARGES	50,614.94	CONTRACTUAL ALLOW	28,772.89
NON-COVERD CHARGES	5,115.25	TOTAL MEDICAID LIAB	21,842.05
		LESS: COB	21,836.05
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0814-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST FRANCIS HOSPITAL, INC
 2122 MANCHESTER EXPY
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	812.44	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,461.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	184.50	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	339.00	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	5,115.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,369.50	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	602.50	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	44,846.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	50,614.94	5,115.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	50,614.94	5,115.25

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

TRINITY HOSPITAL OF AUGUSTA
 2260 WRIGHTSBORO RD
 AUGUSTA,GA 30904-4764

PROVIDER NUMBER 000001779A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,651,030.21	ADJUSTMENTS	24,886.18
COVERED CHARGES	7,548,951.76	CONTRACTUAL ALLOW	5,974,779.55
NON-COVERD CHARGES	102,078.45	TOTAL MEDICAID LIAB	1,574,172.21
		LESS: COB	28,784.22
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,545,387.99

TOTAL NUMBER OF ADMISSIONS 201

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	451		0	586,787.10		71,011.20
ROUTINE NURSERY	46		11	36,553.50		8,769.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	497		11	623,340.60		79,780.20
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	309		0	623,538.85		0.00
NICU	50		0	113,760.00		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	359		0	737,298.85		0.00
TOTAL ACCOMODATIONS	856		11	1,360,639.45		79,780.20

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

TRINITY HOSPITAL OF AUGUSTA
 2260 WRIGHTSBORO RD
 AUGUSTA,GA 30904-4764

PROVIDER NUMBER
 000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,079,728.28	0.00	OTHER LAB	18,749.63	0.00
MED/SURG SUPPLY	948,163.61	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	441,876.47	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	120,584.06	1,543.91	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	113,709.53	1,546.03	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	34,283.59	0.02	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	18,855.70	0.00	MRI SERVICES	5,158.22	0.00
IV THERAPY	22,577.69	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	984,859.99	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	248,482.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	319,380.01	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	401,980.54	0.00	AMBULANCE	0.00	0.00
GI SERVICES	43,685.36	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	296,205.89	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	195,714.34	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	39,363.27	0.00	INJECTABLE DRUGS	6,883.27	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	18,705.41	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	21,963.26	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	91,918.61	6,417.03	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	320,584.53	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	4,079.58
OTHER IMAGING SERVICE	15,773.08	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	86,138.63	997.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	20,085.78	7,714.18			
AUDIOLOGY	10,474.75	0.00			
CARDIOLOGY	197,134.07	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,509.56	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	62,782.68	0.00			
			TOTAL ANCILLARY	6,188,312.31	22,298.25
			TOTAL ACCOMODATIONS	1,360,639.45	79,780.20
			TOTAL CHARGES	7,548,951.76	102,078.45

Report : CLM-0800-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

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TRINITY HOSPITAL OF AUGUSTA
2260 WRIGHTSBORO RD
AUGUSTA,GA 30904-4764

PROVIDER NUMBER
000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013350000085	12/10/13 - 12/11/13	12/23/13	0.00	2,039.79	0.00	0.00	0.00
614	2014128084272	04/03/14 - 04/04/14	05/12/14	0.00	2,039.79	0.00	0.00	0.00
TOTAL				0.00	4,079.58	0.00	0.00	0.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

TRINITY HOSPITAL OF AUGUSTA
 2260 WRIGHTSBORO RD
 AUGUSTA,GA 30904-4764

PROVIDER NUMBER 000001779A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	78,655.77	ADJUSTMENTS	0.00
COVERED CHARGES	78,124.77	CONTRACTUAL ALLOW	63,484.40
NON-COVERD CHARGES	531.00	TOTAL MEDICAID LIAB	14,640.37
		LESS: COB	14,640.37
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3		0	3,951.00		531.00
ROUTINE NURSERY	0		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	3,951.00		531.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	5		0	9,959.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	9,959.00		0.00
TOTAL ACCOMODATIONS	8		0	13,910.00		531.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

TRINITY HOSPITAL OF AUGUSTA
 2260 WRIGHTSBORO RD
 AUGUSTA,GA 30904-4764

PROVIDER NUMBER
 000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,645.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,996.35	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,218.88	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	998.81	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,197.06	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	797.11	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,981.05	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	11,508.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	59.36	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,816.35	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,548.04	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,647.10	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,202.14	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	536.04	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	953.13	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	109.65	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	64,214.77	0.00
			TOTAL ACCOMODATIONS	13,910.00	531.00
			TOTAL CHARGES	78,124.77	531.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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TRINITY HOSPITAL OF AUGUSTA
2260 WRIGHTSBORO RD
AUGUSTA,GA 30904-4764

PROVIDER NUMBER
000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,263,578.94	ADJUSTMENTS	575,500.85
COVERED CHARGES	5,910,483.34	CONTRACTUAL ALLOW	4,781,466.52
NON-COVERD CHARGES	353,095.60	TOTAL MEDICAID LIAB	1,129,016.82
		LESS: COB	6,006.73
		LESS: COPAYMENT	2,358.00
		REIMBURSEMENT	1,120,652.09
		ALL OTHER	1,069,556.69
		FEE SCHEDULE-LAB	45,724.35
		INJECTABLE DRUGS	5,371.05
		TOTAL NUMBER OF CLAIMS	2,071

Report : CLM-0804-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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TRINITY HOSPITAL OF AUGUSTA
 2260 WRIGHTSBORO RD
 AUGUSTA,GA 30904-4764

PROVIDER NUMBER
 000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	168,793.65	21,673.81	OTHER LAB	220,085.83	0.00
MED/SURG SUPPLY	116,370.92	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	159,554.62	589.52	OTHER THERAPEUTIC SVC	245,671.94	1,630.80
CT SCAN	246,992.16	45,404.66	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,952.50	FEE SCHEDULE LAB	400,993.57	78,632.80
EKG/ECG	63,362.93	699.62	MRI SERVICES	10,418.43	0.00
IV THERAPY	357,200.81	10,133.62	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	508,003.58	84,749.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,305.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	35,573.45	766.89	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	498,654.51	0.00	AMBULANCE	0.00	0.00
GI SERVICES	335,432.72	11,681.82	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,259,927.56	2,770.66	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	395,720.87	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	644.00	INJECTABLE DRUGS	93,575.90	17,966.22
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	2,358.26	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	17,273.83	4,176.51	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	59,762.56	20,935.32
LITHOTRIPSY	156,076.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	109,872.50	6,456.03			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	12,192.16	2,047.52			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	30,322.74	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	160,743.35	32,452.04			
AMBULATORY SURGERY	11,328.22	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	234,273.53	5,373.50			
			TOTAL ANCILLARY	5,910,483.34	353,095.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,910,483.34	353,095.60

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TRINITY HOSPITAL OF AUGUSTA
2260 WRIGHTSBORO RD
AUGUSTA,GA 30904-4764

PROVIDER NUMBER
000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	61,282.75	ADJUSTMENTS	0.00
COVERED CHARGES	56,219.53	CONTRACTUAL ALLOW	32,206.94
NON-COVERD CHARGES	5,063.22	TOTAL MEDICAID LIAB	24,012.59
		LESS: COB	23,988.59
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 26

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TRINITY HOSPITAL OF AUGUSTA
 2260 WRIGHTSBORO RD
 AUGUSTA,GA 30904-4764

PROVIDER NUMBER
 000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,368.69	1,231.46	OTHER LAB	5,303.03	0.00
MED/SURG SUPPLY	3,089.33	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	863.40	0.00	OTHER THERAPEUTIC SVC	3,261.60	1,630.80
CT SCAN	0.00	1,098.52	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,235.72	473.52
EKG/ECG	462.28	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	152.45	160.07	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,544.41	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	439.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,778.88	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,424.24	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,751.22	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,140.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	257.84	114.28
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	543.60	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	941.44	354.57			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	662.00	0.00			
			TOTAL ANCILLARY	56,219.53	5,063.22
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	56,219.53	5,063.22

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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Page: 10

TRINITY HOSPITAL OF AUGUSTA
2260 WRIGHTSBORO RD
AUGUSTA,GA 30904-4764

PROVIDER NUMBER
000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	256,732.72	ADJUSTMENTS	964.92
COVERED CHARGES	243,326.32	CONTRACTUAL ALLOW	230,012.60
NON-COVERD CHARGES	13,406.40	TOTAL MEDICAID LIAB	13,313.72
		LESS: COB	0.00
		LESS: COPAYMENT	453.00
		REIMBURSEMENT	12,860.72
		TOTAL NUMBER OF CLAIMS	238

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

TRINITY HOSPITAL OF AUGUSTA
 2260 WRIGHTSBORO RD
 AUGUSTA,GA 30904-4764

PROVIDER NUMBER
 000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,909.10	1,175.83	OTHER LAB	3,016.17	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,209.16	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,172.69	1,098.52	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	19,731.65	2,283.91
EKG/ECG	1,152.70	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	17,736.96	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	938.28	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,958.62	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	5,121.56	CAST ROOM	0.00	0.00
EMERGENCY ROOM	175,624.80	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,219.63	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,342.34	578.58
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	990.58	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	323.64	3,148.00			
			TOTAL ANCILLARY	243,326.32	13,406.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	243,326.32	13,406.40

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
Run Time: 00:32:08
Page: 12

TRINITY HOSPITAL OF AUGUSTA
2260 WRIGHTSBORO RD
AUGUSTA,GA 30904-4764

PROVIDER NUMBER
000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,930.07	ADJUSTMENTS	0.00
COVERED CHARGES	1,893.13	CONTRACTUAL ALLOW	1,306.36
NON-COVERD CHARGES	36.94	TOTAL MEDICAID LIAB	586.77
		LESS: COB	586.77
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TRINITY HOSPITAL OF AUGUSTA
 2260 WRIGHTSBORO RD
 AUGUSTA,GA 30904-4764

PROVIDER NUMBER
 000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7.80	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	768.95	23.44
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,116.38	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	13.50
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	1,893.13	36.94
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,893.13	36.94

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TRINITY HOSPITAL OF AUGUSTA
2260 WRIGHTSBORO RD
AUGUSTA,GA 30904-4764

PROVIDER NUMBER
000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	831,621.12	ADJUSTMENTS	48,971.78
COVERED CHARGES	724,578.14	CONTRACTUAL ALLOW	641,590.32
NON-COVERD CHARGES	107,042.98	TOTAL MEDICAID LIAB	82,987.82
		LESS: COB	0.00
		LESS: COPAYMENT	57.00
		REIMBURSEMENT	82,930.82
		TOTAL NUMBER OF CLAIMS	15

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TRINITY HOSPITAL OF AUGUSTA
 2260 WRIGHTSBORO RD
 AUGUSTA,GA 30904-4764

PROVIDER NUMBER
 000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,602.08	3,132.00	OTHER LAB	1,663.52	0.00
MED/SURG SUPPLY	52,637.29	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,883.06	0.00	OTHER THERAPEUTIC SVC	30,822.12	0.00
CT SCAN	0.00	6,359.30	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,582.15	4,489.14
EKG/ECG	2,333.96	710.34	MRI SERVICES	0.00	0.00
IV THERAPY	30,548.99	326.12	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	95,584.45	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	14,241.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	28.26	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	39,149.88	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,636.36	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,406.15	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	28,302.11	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,881.50	9,281.85
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,245.96	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,394.27	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	64,838.14	43,185.05
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	403.71	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,057.32	914.60			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,654.88	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	188,847.76	29,143.62			
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	91,079.18	7,255.00			
			TOTAL ANCILLARY	724,578.14	107,042.98
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	724,578.14	107,042.98

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TRINITY HOSPITAL OF AUGUSTA
2260 WRIGHTSBORO RD
AUGUSTA,GA 30904-4764

PROVIDER NUMBER
000001779A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
 Run Time: 00:32:17
 Page: 1

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	31,928,082.59	ADJUSTMENTS	858,479.21
COVERED CHARGES	31,287,566.15	CONTRACTUAL ALLOW	23,834,020.94
NON-COVERD CHARGES	640,516.44	TOTAL MEDICAID LIAB	7,453,545.21
		LESS: COB	70,752.10
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,382,793.11

TOTAL NUMBER OF ADMISSIONS 519

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,260		0	1,073,625.00		28,875.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,260		0	1,073,625.00		28,875.00
SPECIAL CARE SERVICES						
CCU	388		0	1,141,554.00		8,892.00
ICU	2,148		6	3,702,342.00		40,484.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,536		6	4,843,896.00		49,376.00
TOTAL ACCOMODATIONS	3,796		6	5,917,521.00		78,251.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,161,372.08	111,503.00	OTHER LAB	105,320.00	453.00
MED/SURG SUPPLY	1,895,667.30	21,873.44	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,822,627.00	75,492.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,061,182.00	11,474.00	OTHER THERAPEUTIC SVC	396.00	0.00
CT SCAN	983,996.00	34,141.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	308,686.62	813.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	81,324.00	242.00	MRI SERVICES	343,778.00	4,332.00
IV THERAPY	123,408.00	5,058.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,171,772.00	19,070.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,642,209.00	17,997.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	665,713.00	1,192.00	AMBULANCE	0.00	0.00
GI SERVICES	107,532.00	4,410.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	402,914.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	362,877.00	1,587.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	121,365.00	908.00	INJECTABLE DRUGS	2,849,678.31	57,663.00
RADIOLOGY THERAPEUTIC	55,276.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	130,718.63	1,177.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	146,533.21	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	235,575.00	1,517.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,621,020.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	142,166.00	7,780.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	866,407.00	91,173.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	113,716.00	92,410.00			
AUDIOLOGY	2,321.00	0.00			
CARDIOLOGY	765,833.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	34,808.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	43,854.00	0.00			
			TOTAL ANCILLARY	25,370,045.15	562,265.44
			TOTAL ACCOMODATIONS	5,917,521.00	78,251.00
			TOTAL CHARGES	31,287,566.15	640,516.44

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
 Run Time: 00:32:21
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,685.00	ADJUSTMENTS	0.00
COVERED CHARGES	19,547.00	CONTRACTUAL ALLOW	10,737.09
NON-COVERD CHARGES	2,138.00	TOTAL MEDICAID LIAB	8,809.91
		LESS: COB	8,809.91
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	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	1		0	1,187.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1		0	1,187.00		0.00
TOTAL ACCOMODATIONS	1		0	1,187.00		0.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	161.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,032.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	890.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	412.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	121.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	1,526.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,622.00	2,138.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	10,596.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	18,360.00	2,138.00
			TOTAL ACCOMODATIONS	1,187.00	0.00
			TOTAL CHARGES	19,547.00	2,138.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
Run Time: 00:32:22
Page: 5

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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,499,932.41	ADJUSTMENTS	236,290.73
COVERED CHARGES	6,002,854.57	CONTRACTUAL ALLOW	4,772,926.19
NON-COVERD CHARGES	497,077.84	TOTAL MEDICAID LIAB	1,229,928.38
		LESS: COB	27,653.09
		LESS: COPAYMENT	1,637.23
		REIMBURSEMENT	1,200,638.06
		ALL OTHER	1,101,557.57
		FEE SCHEDULE-LAB	87,831.94
		INJECTABLE DRUGS	11,248.55
		TOTAL NUMBER OF CLAIMS	2,453

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	267,443.00	28,795.00	OTHER LAB	48,859.00	0.00
MED/SURG SUPPLY	243,064.90	4,852.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	437,557.00	11,341.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	606,386.00	55,308.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	32,262.00	9,742.08	FEE SCHEDULE LAB	587,698.00	79,175.40
EKG/ECG	47,553.00	1,331.00	MRI SERVICES	142,054.00	14,774.00
IV THERAPY	337,105.00	8,428.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	639,061.17	78,445.36	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	49,535.00	532.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	188,619.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	19,110.00	2,940.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,045,961.00	1,648.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	258,826.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	169,172.00	6,936.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,603.00	1,692.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,684.00	842.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,551.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	197,308.00	36,231.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	93,757.00	12,220.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	19,815.00	3,240.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	40,945.00	0.00			
AUDIOLOGY	159,062.00	21,298.00			
CARDIOLOGY	329,836.50	105,393.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,192.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	29,386.00	7,363.00			
			TOTAL ANCILLARY	6,002,854.57	497,077.84
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,002,854.57	497,077.84

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	193,644.80	ADJUSTMENTS	0.00
COVERED CHARGES	135,309.80	CONTRACTUAL ALLOW	83,905.48
NON-COVERD CHARGES	58,335.00	TOTAL MEDICAID LIAB	51,404.32
		LESS: COB	51,347.95
		LESS: COPAYMENT	56.37
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 59

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,120.00	1,179.00	OTHER LAB	1,230.00	0.00
MED/SURG SUPPLY	10,283.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,541.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,996.00	14,682.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,893.00	3,711.00
EKG/ECG	847.00	0.00	MRI SERVICES	0.00	2,126.00
IV THERAPY	10,504.00	1,694.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,019.00	14,784.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,346.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,890.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	735.00	5,145.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	25,708.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,991.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,018.00	1,155.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,077.00	2,802.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,477.00	1,864.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,583.00	0.00			
AUDIOLOGY	5,051.00	9,193.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	135,309.80	58,335.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	135,309.80	58,335.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
Run Time: 00:32:40
Page: 9

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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	418,610.00	ADJUSTMENTS	844.04
COVERED CHARGES	399,682.00	CONTRACTUAL ALLOW	380,606.47
NON-COVERD CHARGES	18,928.00	TOTAL MEDICAID LIAB	19,075.53
		LESS: COB	0.00
		LESS: COPAYMENT	705.01
		REIMBURSEMENT	18,370.52
		TOTAL NUMBER OF CLAIMS	341

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,520.00	610.00	OTHER LAB	5,121.00	0.00
MED/SURG SUPPLY	604.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	34,143.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,517.00	6,154.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	57,126.00	7,375.00
EKG/ECG	4,598.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	38,237.00	699.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,064.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	200,956.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,140.00	2,334.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,196.00	1,756.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	460.00	0.00			
			TOTAL ANCILLARY	399,682.00	18,928.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	399,682.00	18,928.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
Run Time: 00:32:43
Page: 11

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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,168.00	ADJUSTMENTS	0.00
COVERED CHARGES	10,293.00	CONTRACTUAL ALLOW	5,913.50
NON-COVERD CHARGES	3,875.00	TOTAL MEDICAID LIAB	4,379.50
		LESS: COB	4,370.50
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 9

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	352.00	37.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	28.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	816.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,118.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,024.00	188.00
EKG/ECG	121.00	0.00	MRI SERVICES	0.00	2,018.00
IV THERAPY	230.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	133.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,103.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	100.00	200.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	386.00	314.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	10,293.00	3,875.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,293.00	3,875.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,693,591.48	ADJUSTMENTS	51,814.27
COVERED CHARGES	1,625,628.74	CONTRACTUAL ALLOW	1,463,391.76
NON-COVERD CHARGES	67,962.74	TOTAL MEDICAID LIAB	162,236.98
		LESS: COB	0.00
		LESS: COPAYMENT	150.00
		REIMBURSEMENT	162,086.98
		TOTAL NUMBER OF CLAIMS	28

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,892.00	7,442.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	162,579.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	23,521.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	3,078.03	FEE SCHEDULE LAB	9,239.00	411.00
EKG/ECG	1,331.00	0.00	MRI SERVICES	2,292.00	2,126.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	228,050.80	35,211.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	71,687.00	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	98,838.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,975.00	977.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	631.05	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	868,161.60	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,092.00	1,023.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,141.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	95,829.34	15,283.66			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	1,780.00			
			TOTAL ANCILLARY	1,625,628.74	67,962.74
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,625,628.74	67,962.74

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
Run Time: 00:32:44
Page: 15

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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE I
 INPATIENT PAID CLAIMS

Run Date: 07/15/2015
 Run Time: 00:32:51
 Page: 1

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,628,563.57	ADJUSTMENTS	584,859.60
COVERED CHARGES	23,256,369.13	CONTRACTUAL ALLOW	16,308,366.26
NON-COVERD CHARGES	372,194.44	TOTAL MEDICAID LIAB	6,948,002.87
		LESS: COB	181,313.05
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,766,689.82

TOTAL NUMBER OF ADMISSIONS 496

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,544		0	3,096,048.00		176,797.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,544		0	3,096,048.00		176,797.00
SPECIAL CARE SERVICES						
CCU	207		0	912,935.00		0.00
ICU	864		0	2,779,660.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,071		0	3,692,595.00		0.00
TOTAL ACCOMODATIONS	3,615		0	6,788,643.00		176,797.00

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,362,084.63	70.00	OTHER LAB	152,284.00	0.00
MED/SURG SUPPLY	1,478,314.00	13,504.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,660,344.00	10,644.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	433,296.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	901,420.00	577.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	134,017.94	1,536.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	85,727.00	0.00	MRI SERVICES	286,957.00	0.00
IV THERAPY	13,137.00	2,134.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,342,778.00	4,955.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	847,452.00	1,468.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	469,479.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	104,836.00	1,612.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	531,653.00	2,483.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	121,081.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	39,820.92
LABORATORY PATHOLOGIC	129,194.00	584.00	INJECTABLE DRUGS	1,675,238.80	17.52
RADIOLOGY THERAPEUTIC	2,446.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	52,768.22	409.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	39,021.27	991.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	159,353.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	190.00	894.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	9,646.00	0.00	IMPL DEV CHARGE PATIENTS	517,854.27	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	97,951.00
OTHER IMAGING SERVICE	69,649.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	274,014.00	143.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	104,794.00	14,078.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,460,972.00	1,526.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	15,105.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	32,620.00	0.00			
			TOTAL ANCILLARY	16,467,726.13	195,397.44
			TOTAL ACCOMODATIONS	6,788,643.00	176,797.00
			TOTAL CHARGES	23,256,369.13	372,194.44

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014052029261	09/09/13 - 09/14/13	02/24/14	0.00	6,282.00	0.00	0.00	0.00
614	2014084038604	02/28/14 - 03/16/14	03/31/14	0.00	6,282.00	0.00	0.00	0.00
614	2014133016611	12/06/13 - 12/10/13	05/19/14	0.00	2,768.00	0.00	0.00	0.00
614	2014155048082	04/10/14 - 04/21/14	06/09/14	0.00	6,273.00	0.00	0.00	0.00
614	2014191022642	10/23/13 - 10/30/13	07/14/14	0.00	6,282.00	0.00	0.00	0.00
615	2014192022050	02/09/14 - 02/10/14	07/14/14	0.00	2,871.00	0.00	0.00	0.00
614	2014195001919	11/16/13 - 12/14/13	07/21/14	0.00	2,135.00	0.00	0.00	0.00
614	2214197001846	06/09/14 - 06/11/14	07/21/14	0.00	2,135.00	0.00	0.00	0.00
614	2014220008094	07/29/14 - 08/02/14	08/11/14	0.00	6,282.00	0.00	0.00	0.00
614	2214234019899	11/30/13 - 12/06/13	09/01/14	0.00	6,282.00	0.00	0.00	0.00
615	2014237002606	08/14/14 - 08/18/14	09/01/14	0.00	11,228.00	0.00	0.00	0.00
614	9114233004341	06/18/14 - 06/26/14	09/08/14	0.00	6,273.00	0.00	1,253.91	0.00
614	9114253003360	07/18/14 - 07/22/14	09/22/14	0.00	2,768.00	0.00	1,295.84	0.00
614	2214274008577	08/26/14 - 08/31/14	10/06/14	0.00	6,273.00	0.00	0.00	0.00
615	2214297017631	04/09/14 - 04/17/14	10/27/14	0.00	8,485.00	0.00	0.00	0.00
614	9114304003826	07/07/14 - 07/12/14	11/17/14	0.00	2,768.00	0.00	1,558.19	0.00
614	2315163000226	08/14/14 - 09/02/14	06/22/15	0.00	12,564.00	0.00	0.00	0.00
TOTAL				0.00	97,951.00	0.00	4,107.94	0.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
 Run Time: 00:32:54
 Page: 4

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	252,192.47	ADJUSTMENTS	0.00
COVERED CHARGES	250,072.47	CONTRACTUAL ALLOW	120,506.37
NON-COVERD CHARGES	2,120.00	TOTAL MEDICAID LIAB	129,566.10
		LESS: COB	129,566.10
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 7

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	30		0	36,510.00		2,040.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	30		0	36,510.00		2,040.00
SPECIAL CARE SERVICES						
CCU	8		0	35,240.00		0.00
ICU	5		0	9,925.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	13		0	45,165.00		0.00
TOTAL ACCOMODATIONS	43		0	81,675.00		2,040.00

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,609.82	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,764.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	27,498.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,377.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,623.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	841.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,179.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	18,422.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,079.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,876.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,635.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,417.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	53,023.65	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	80.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	671.00	0.00	IMPL DEV CHARGE PATIENTS	12,531.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	688.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,731.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,432.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	168,397.47	80.00
			TOTAL ACCOMODATIONS	81,675.00	2,040.00
			TOTAL CHARGES	250,072.47	2,120.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
Run Time: 00:32:55
Page: 6

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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,611,027.99	ADJUSTMENTS	123,988.71
COVERED CHARGES	3,145,437.59	CONTRACTUAL ALLOW	2,450,767.13
NON-COVERD CHARGES	1,465,590.40	TOTAL MEDICAID LIAB	694,670.46
		LESS: COB	18,149.82
		LESS: COPAYMENT	1,686.00
		REIMBURSEMENT	674,834.64
		ALL OTHER	618,379.32
		FEE SCHEDULE-LAB	45,464.25
		INJECTABLE DRUGS	10,991.07
		TOTAL NUMBER OF CLAIMS	1,270

Report : CLM-0804-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
 Run Time: 00:32:55
 Page: 7

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,626.03	41,457.54	OTHER LAB	82,818.00	0.00
MED/SURG SUPPLY	99,307.00	163,542.09	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	2,342.00	EDUCATION & TRAINING	0.00	92.00
RADIOLOGY-DIAGNOSTIC	151,669.00	13,328.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	249,187.00	259,612.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	706.00	FEE SCHEDULE LAB	372,028.10	59,589.90
EKG/ECG	32,357.00	1,703.00	MRI SERVICES	219,829.00	49,380.00
IV THERAPY	1,741.00	2,431.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	392,240.00	44,884.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	21,626.00	7,868.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	88,411.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	9,901.00	18,556.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	600,014.00	17,262.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	76,170.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	55,463.95	68,801.87
RADIOLOGY THERAPEUTIC	11,867.00	35,137.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	581.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	240.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,559.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	12,003.00	819.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	660.00	462.00	IMPL DEV CHARGE PATIENTS	9,054.39	95,674.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	28,266.00
OTHER IMAGING SERVICE	146,129.00	65,892.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,676.00	128.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	152,942.00	25,071.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	257,549.00	449,236.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	69,929.12	4,355.00			
			TOTAL ANCILLARY	3,145,437.59	1,461,735.40
			TOTAL ACCOMODATIONS	0.00	3,855.00
			TOTAL CHARGES	3,145,437.59	1,465,590.40

Report : CLM-0804-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

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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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013284025366	09/12/13 - 09/12/13	10/14/13	0.00	2,841.00	0.00	0.00	0.00
614	5913315000759	09/16/13 - 09/16/13	11/18/13	0.00	5,434.00	0.00	0.00	0.00
614	2014107026055	04/11/14 - 04/11/14	04/21/14	0.00	2,841.00	0.00	0.00	0.00
614	2014111001678	04/11/14 - 04/11/14	04/28/14	0.00	6,282.00	0.00	0.00	0.00
614	2014141019401	05/13/14 - 05/13/14	05/26/14	0.00	5,434.00	0.00	0.00	0.00
614	2014170061339	05/27/14 - 05/27/14	06/23/14	0.00	5,434.00	0.00	0.00	0.00
TOTAL				0.00	28,266.00	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

Run Date: 07/15/2015
Run Time: 00:33:03
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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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	58,841.12	ADJUSTMENTS	0.00
COVERED CHARGES	30,362.68	CONTRACTUAL ALLOW	12,838.36
NON-COVERD CHARGES	28,478.44	TOTAL MEDICAID LIAB	17,524.32
		LESS: COB	17,502.67
		LESS: COPAYMENT	21.65
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 22

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	365.19	1,327.31	OTHER LAB	2,361.00	0.00
MED/SURG SUPPLY	578.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	708.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,984.00	9,892.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,138.00	677.00
EKG/ECG	524.00	0.00	MRI SERVICES	0.00	6,141.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	302.00	1,440.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,612.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,486.00	654.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	448.49	453.13
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	6,282.00
OTHER IMAGING SERVICE	895.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,573.00	0.00			
			TOTAL ANCILLARY	30,362.68	28,478.44
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	30,362.68	28,478.44

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

Run Date: 07/15/2015
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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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014255009323	08/15/14 - 08/15/14	09/15/14	0.00	6,282.00	0.00	57.73	0.00
TOTAL				0.00	6,282.00	0.00	57.73	0.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	110,484.00	ADJUSTMENTS	108.87
COVERED CHARGES	103,445.05	CONTRACTUAL ALLOW	98,913.90
NON-COVERD CHARGES	7,038.95	TOTAL MEDICAID LIAB	4,531.15
		LESS: COB	0.00
		LESS: COPAYMENT	225.00
		REIMBURSEMENT	4,306.15
		TOTAL NUMBER OF CLAIMS	82

Report : CLM-0808-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	261.79	131.56	OTHER LAB	945.00	0.00
MED/SURG SUPPLY	2,618.00	1,257.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,949.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,120.00	1,955.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	16,664.00	2,049.00
EKG/ECG	1,310.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,420.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	251.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,156.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	8,531.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	50,311.00	109.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,836.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	967.26	946.39
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	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,934.00	591.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	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	103,445.05	7,038.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	103,445.05	7,038.95

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,701.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,638.00	CONTRACTUAL ALLOW	1,091.19
NON-COVERD CHARGES	63.00	TOTAL MEDICAID LIAB	546.81
		LESS: COB	543.81
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9.00	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	317.00	63.00
EKG/ECG	131.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,029.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,638.00	63.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,638.00	63.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII

Run Date: 07/15/2015
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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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	296,365.79	ADJUSTMENTS	0.00
COVERED CHARGES	245,312.55	CONTRACTUAL ALLOW	200,881.47
NON-COVERD CHARGES	51,053.24	TOTAL MEDICAID LIAB	44,431.08
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	44,416.08

TOTAL NUMBER OF CLAIMS 7

Report : CLM-0812-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	856.28	1,812.24	OTHER LAB	500.00	0.00
MED/SURG SUPPLY	5,284.00	7,960.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	23,224.00	152.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,882.00	3,783.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,134.00	242.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	3,322.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	71,427.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	618.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,588.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	34,090.00	218.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,313.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	768.27	2,637.00
RADIOLOGY THERAPEUTIC	48,848.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	12,422.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	31,708.00	17,887.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,690.00	0.00			
			TOTAL ANCILLARY	245,312.55	51,053.24
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	245,312.55	51,053.24

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
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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	09/01/13	THROUGH	08/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF 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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,237,448.93	ADJUSTMENTS	299,595.84
COVERED CHARGES	11,002,444.75	CONTRACTUAL ALLOW	7,338,044.99
NON-COVERD CHARGES	1,235,004.18	TOTAL MEDICAID LIAB	3,664,399.76
		LESS: COB	28,668.55
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,635,731.21

TOTAL NUMBER OF ADMISSIONS 399

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	895		1	670,258.00		234,771.00
ROUTINE NURSERY	254		0	221,890.00		3,712.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,149		1	892,148.00		238,483.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	735		0	1,343,774.00		9,920.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		379	0.00		380,614.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	735		379	1,343,774.00		390,534.00
TOTAL ACCOMODATIONS	1,884		380	2,235,922.00		629,017.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,170,934.97	81,288.65	OTHER LAB	87,415.00	0.00
MED/SURG SUPPLY	381,833.15	3,836.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	637,654.75	2,426.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	253,572.00	352.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	420,828.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	182,643.00	16,499.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	70,082.00	0.00	MRI SERVICES	246,186.00	0.00
IV THERAPY	164,098.45	3,377.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,022,708.00	13,945.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	155,509.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	541,441.00	4,611.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	310,732.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	27,177.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	329,255.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	210,131.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	30,607.00	0.00	INJECTABLE DRUGS	7,011.43	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	149,585.00	14,914.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	124,173.00	16,265.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	47,434.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	816.48	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	147.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	351.00	0.00	IMPL DEV CHARGE PATIENTS	1,003,626.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	14,173.05
OTHER IMAGING SERVICE	76,643.00	0.00			
BLOOD	2,564.00	0.00			
BLOOD STORAGE & PRO.	92,970.00	8,642.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	17,533.00	3,867.00			
AUDIOLOGY	6,685.00	0.00			
CARDIOLOGY	396,801.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	14,595.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,572.00	0.00			
			TOTAL ANCILLARY	8,766,522.75	605,987.18
			TOTAL ACCOMODATIONS	2,235,922.00	629,017.00
			TOTAL CHARGES	11,002,444.75	1,235,004.18

Report : CLM-0800-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

Run Date: 07/15/2015
Run Time: 00:33:12
Page: 3

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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014171083432	01/04/14 - 01/14/14	06/30/14	0.00	1,800.00	0.00	0.00	0.00
-1	1114190000251	06/09/14 - 06/18/14	08/11/14	0.00	155.05	0.00	0.00	0.00
615	2015029079139	04/27/14 - 04/30/14	02/02/15	0.00	2,395.00	0.00	0.00	0.00
615	2015050094821	05/27/14 - 05/27/14	02/23/15	0.00	2,395.00	0.00	0.00	0.00
614	2015112071465	06/10/14 - 06/14/14	04/27/15	0.00	2,651.00	0.00	0.00	0.00
615	2015189093048	02/15/14 - 02/28/14	07/13/15	0.00	2,395.00	0.00	0.00	0.00
615	2015189093048	02/15/14 - 02/28/14	07/13/15	0.00	2,382.00	0.00	0.00	0.00
TOTAL				0.00	14,173.05	0.00	0.00	0.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
 Run Time: 00:33:16
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,096.72	ADJUSTMENTS	0.00
COVERED CHARGES	17,008.72	CONTRACTUAL ALLOW	12,324.75
NON-COVERD CHARGES	1,088.00	TOTAL MEDICAID LIAB	4,683.97
		LESS: COB	4,683.97
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	4		0	3,000.00		1,088.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	4		0	3,000.00		1,088.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	4		0	3,000.00		1,088.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	623.71	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	242.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	571.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	6,507.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	162.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,027.00	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	1,304.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	481.00	0.00	INJECTABLE DRUGS	2,091.01	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	14,008.72	0.00
			TOTAL ACCOMODATIONS	3,000.00	1,088.00
			TOTAL CHARGES	17,008.72	1,088.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
Run Time: 00:33:17
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,659,005.41	ADJUSTMENTS	224,857.57
COVERED CHARGES	9,537,557.19	CONTRACTUAL ALLOW	7,384,747.14
NON-COVERD CHARGES	1,121,448.22	TOTAL MEDICAID LIAB	2,152,810.05
		LESS: COB	8,362.26
		LESS: COPAYMENT	4,911.38
		REIMBURSEMENT	2,139,536.41
		ALL OTHER	1,861,935.08
		FEE SCHEDULE-LAB	142,147.67
		INJECTABLE DRUGS	135,453.66

TOTAL NUMBER OF CLAIMS 4,739

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	277,490.26	2,662.03	OTHER LAB	74,355.00	0.00
MED/SURG SUPPLY	191,908.50	79,957.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	353.80	EDUCATION & TRAINING	654.00	0.00
RADIOLOGY-DIAGNOSTIC	573,307.00	11,101.00	OTHER THERAPEUTIC SVC	0.00	20,173.00
CT SCAN	716,464.00	74,172.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	43,290.00	15,618.00	FEE SCHEDULE LAB	607,011.93	125,442.20
EKG/ECG	135,303.00	5,268.00	MRI SERVICES	357,854.00	12,814.00
IV THERAPY	734,937.00	46,111.32	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,125,364.33	129,111.67	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,630.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	102,648.00	34,882.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	380,964.00	4,568.00	AMBULANCE	0.00	0.00
GI SERVICES	22,348.00	1,950.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,668,781.00	28,006.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	437,948.00	1,806.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	766,439.17	221,596.70
RADIOLOGY THERAPEUTIC	17,001.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	11,052.00	8,100.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	15,783.00	7,115.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	48.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	89,581.00	4,664.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	14,083.00	0.00	IMPL DEV CHARGE PATIENTS	14,939.00	89,315.00
LITHOTRIPSY	16,852.00	0.00	NO CC/INVALID REV CODE	0.00	3,635.80
OTHER IMAGING SERVICE	199,389.00	24,342.70			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	20,861.00	20,281.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	187,498.00	45,144.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	422,313.00	101,849.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	177,567.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	126,941.00	1,361.00			
			TOTAL ANCILLARY	9,537,557.19	1,121,448.22
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,537,557.19	1,121,448.22

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
618	1113255001565	07/31/13 - 07/31/13	10/28/13	0.00	35.80	0.00	0.00	0.00
780	2014122088353	04/25/14 - 04/25/14	05/12/14	0.00	90.00	0.00	0.00	0.00
780	2014122088353	04/25/14 - 04/25/14	05/12/14	0.00	3,510.00	0.00	0.00	0.00
TOTAL				0.00	3,635.80	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	102,931.34	ADJUSTMENTS	0.00
COVERED CHARGES	67,036.93	CONTRACTUAL ALLOW	33,665.00
NON-COVERD CHARGES	35,894.41	TOTAL MEDICAID LIAB	33,371.93
		LESS: COB	33,335.34
		LESS: COPAYMENT	36.59
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 74

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,411.70	0.00	OTHER LAB	970.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	457.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,781.00	0.00	OTHER THERAPEUTIC SVC	0.00	162.00
CT SCAN	1,968.00	5,131.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,656.00	1,834.00
EKG/ECG	1,903.00	232.00	MRI SERVICES	7,727.00	9,714.00
IV THERAPY	7,872.65	3,516.06	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	960.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	3,497.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,824.00	1,417.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	307.00	INJECTABLE DRUGS	2,460.58	2,648.35
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	514.00	2,112.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,671.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,463.00	1,441.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	363.00	740.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,174.00	690.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,606.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	712.00	1,971.00			
			TOTAL ANCILLARY	67,036.93	35,869.41
			TOTAL ACCOMODATIONS	0.00	25.00
			TOTAL CHARGES	67,036.93	35,894.41

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	649,318.30	ADJUSTMENTS	1,432.37
COVERED CHARGES	615,703.12	CONTRACTUAL ALLOW	574,922.90
NON-COVERD CHARGES	33,615.18	TOTAL MEDICAID LIAB	40,780.22
		LESS: COB	0.00
		LESS: COPAYMENT	1,431.01
		REIMBURSEMENT	39,349.21
		TOTAL NUMBER OF CLAIMS	729

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,162.61	0.00	OTHER LAB	1,566.00	0.00
MED/SURG SUPPLY	0.00	1,759.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	166.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	85,656.00	349.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,086.00	1,899.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	654.00	FEE SCHEDULE LAB	40,398.00	11,638.00
EKG/ECG	4,653.00	0.00	MRI SERVICES	6,375.00	0.00
IV THERAPY	42,920.00	2,252.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,752.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,353.00	324.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,402.00	514.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	347,227.00	1,209.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,927.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,726.51	9,595.18
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	390.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	254.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,393.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,176.00	1,278.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,322.00	1,334.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,608.00	0.00			
			TOTAL ANCILLARY	615,703.12	33,615.18
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	615,703.12	33,615.18

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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Page: 13

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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,799.90	ADJUSTMENTS	0.00
COVERED CHARGES	11,327.90	CONTRACTUAL ALLOW	4,921.69
NON-COVERD CHARGES	5,472.00	TOTAL MEDICAID LIAB	6,406.21
		LESS: COB	6,397.21
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	9

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	441.30	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	2,799.00	862.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,899.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,204.00	236.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	755.00	392.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,404.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	71.60	85.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	653.00	1,998.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	11,327.90	5,472.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,327.90	5,472.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,201,009.19	ADJUSTMENTS	27,975.00
COVERED CHARGES	890,428.85	CONTRACTUAL ALLOW	762,125.90
NON-COVERD CHARGES	310,580.34	TOTAL MEDICAID LIAB	128,302.95
		LESS: COB	3,902.64
		LESS: COPAYMENT	116.93
		REIMBURSEMENT	124,283.38

TOTAL NUMBER OF CLAIMS 23

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,295.74	14.20	OTHER LAB	970.00	0.00
MED/SURG SUPPLY	81,888.00	17,961.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,246.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,151.00	1,843.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	930.00	FEE SCHEDULE LAB	8,324.00	1,564.00
EKG/ECG	2,517.00	464.00	MRI SERVICES	11,034.00	0.00
IV THERAPY	11,652.38	3,954.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	386,992.00	7,399.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	486.00	648.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	50,245.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,922.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	99,320.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	93,435.73	9,601.14
RADIOLOGY THERAPEUTIC	2,466.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	390.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	21,392.00	256,021.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	810.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	74,651.00	9,645.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,631.00	0.00			
			TOTAL ANCILLARY	890,428.85	310,434.34
			TOTAL ACCOMODATIONS	0.00	146.00
			TOTAL CHARGES	890,428.85	310,580.34

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF 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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,845,731.41	ADJUSTMENTS	4,063.40
COVERED CHARGES	2,819,169.00	CONTRACTUAL ALLOW	1,655,032.94
NON-COVERD CHARGES	26,562.41	TOTAL MEDICAID LIAB	1,164,136.06
		LESS: COB	8,221.88
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,155,914.18

TOTAL NUMBER OF ADMISSIONS 160

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	378		0	213,570.00		17,700.00
ROUTINE NURSERY	31		2	14,105.00		910.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	409		2	227,675.00		18,610.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	324		0	378,855.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	324		0	378,855.00		0.00
TOTAL ACCOMODATIONS	733		2	606,530.00		18,610.00

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	442,516.90	0.00	OTHER LAB	8,177.95	0.00
MED/SURG SUPPLY	657,712.09	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	283,015.73	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	59,118.40	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	86,526.00	3,719.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	30,473.62	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	15,690.00	0.00	MRI SERVICES	11,153.00	0.00
IV THERAPY	16,160.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	73,720.05	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	35,986.36	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	210,289.55	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	29,486.30	0.00	AMBULANCE	0.00	0.00
GI SERVICES	9,861.75	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	69,647.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,320.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	5,147.05	0.00	INJECTABLE DRUGS	13,577.04	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,338.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	817.75	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	3,958.50	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,451.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,737.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	13,138.35	292.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	13,817.75	3,940.66			
AUDIOLOGY	1,183.50	0.00			
CARDIOLOGY	24,544.75	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	57,071.36	0.00			
			TOTAL ANCILLARY	2,212,639.00	7,952.41
			TOTAL ACCOMODATIONS	606,530.00	18,610.00
			TOTAL CHARGES	2,819,169.00	26,562.41

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

Run Date: 07/15/2015
 Run Time: 00:34:00
 Page: 3

STEPHENS COUNTY HOSPITAL
 163 HOSPITAL DR
 TOCCOA,GA 30577-6820

PROVIDER NUMBER 000001834A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	37,046.10	ADJUSTMENTS	0.00
COVERED CHARGES	36,706.10	CONTRACTUAL ALLOW	9,996.12
NON-COVERD CHARGES	340.00	TOTAL MEDICAID LIAB	26,709.98
		LESS: COB	26,709.98
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	8		0	4,520.00		340.00
ROUTINE NURSERY	0		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	4,520.00		340.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	4,520.00		340.00

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,748.79	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	12,077.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,319.31	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	205.75	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	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	320.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,595.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,455.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,990.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,454.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	589.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,136.50	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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,293.75	0.00			
			TOTAL ANCILLARY	32,186.10	0.00
			TOTAL ACCOMODATIONS	4,520.00	340.00
			TOTAL CHARGES	36,706.10	340.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,713,316.40	ADJUSTMENTS	51,602.26
COVERED CHARGES	2,515,489.55	CONTRACTUAL ALLOW	1,647,940.08
NON-COVERD CHARGES	197,826.85	TOTAL MEDICAID LIAB	867,549.47
		LESS: COB	2,381.55
		LESS: COPAYMENT	3,356.89
		REIMBURSEMENT	861,811.03
		ALL OTHER	808,795.43
		FEE SCHEDULE-LAB	48,622.74
		INJECTABLE DRUGS	4,392.86

TOTAL NUMBER OF CLAIMS 2,263

STEPHENS COUNTY HOSPITAL
 163 HOSPITAL DR
 TOCCOA,GA 30577-6820

PROVIDER NUMBER
 000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	149,535.74	29,845.35	OTHER LAB	31,629.75	1,449.50
MED/SURG SUPPLY	444,128.38	971.04	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	110,416.00	6,250.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	221,040.00	12,548.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	64,495.25	9,461.27	FEE SCHEDULE LAB	283,159.13	45,674.26
EKG/ECG	23,389.25	2,882.00	MRI SERVICES	97,593.00	1,476.50
IV THERAPY	29,935.00	1,940.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	112,703.71	20,724.04	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	779.50	129.50	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	49,559.75	5,829.42	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	66,190.75	2,772.75	AMBULANCE	0.00	0.00
GI SERVICES	28,048.50	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	315,829.75	2,800.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	81,439.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,406.00	13,827.08
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	915.25	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	5,385.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	650.62
OTHER IMAGING SERVICE	51,089.50	3,342.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,332.00	5,119.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	60,714.75	13,571.39			
AUDIOLOGY	156.50	0.00			
CARDIOLOGY	4,760.50	4,347.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	564.50	564.50			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	267,292.59	11,650.13			
			TOTAL ANCILLARY	2,515,489.55	197,826.85
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,515,489.55	197,826.85

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
60	5914174000691	03/18/14 - 03/18/14	06/30/14	0.00	650.62	0.00	0.00	0.00
TOTAL				0.00	650.62	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	60,095.11	ADJUSTMENTS	0.00
COVERED CHARGES	54,902.89	CONTRACTUAL ALLOW	18,976.13
NON-COVERD CHARGES	5,192.22	TOTAL MEDICAID LIAB	35,926.76
		LESS: COB	35,917.76
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 61

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,266.79	599.84	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,012.21	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,044.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,117.50	1,656.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,870.00	1,755.13
EKG/ECG	164.75	494.25	MRI SERVICES	0.00	0.00
IV THERAPY	415.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,326.75	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	2,381.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,402.50	375.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,422.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,193.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,287.14	312.00			
			TOTAL ANCILLARY	54,902.89	5,192.22
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	54,902.89	5,192.22

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	222,787.04	ADJUSTMENTS	432.52
COVERED CHARGES	214,741.14	CONTRACTUAL ALLOW	185,876.10
NON-COVERD CHARGES	8,045.90	TOTAL MEDICAID LIAB	28,865.04
		LESS: COB	79.25
		LESS: COPAYMENT	822.00
		REIMBURSEMENT	27,963.79
		TOTAL NUMBER OF CLAIMS	516

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,734.09	3,409.42	OTHER LAB	633.25	0.00
MED/SURG SUPPLY	6,584.02	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,962.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,871.75	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	29,997.78	3,660.98
EKG/ECG	1,812.25	0.00	MRI SERVICES	1,449.00	0.00
IV THERAPY	1,690.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,098.75	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	650.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,030.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	125,200.25	455.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,472.75	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	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,975.75	519.75			
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	1,578.25	0.00			
			TOTAL ANCILLARY	214,741.14	8,045.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	214,741.14	8,045.90

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,373.78	ADJUSTMENTS	0.00
COVERED CHARGES	2,713.98	CONTRACTUAL ALLOW	573.80
NON-COVERD CHARGES	659.80	TOTAL MEDICAID LIAB	2,140.18
		LESS: COB	2,140.18
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	165.01	6.80	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	74.50	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	841.47	58.25
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	170.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,463.00	75.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	519.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,713.98	659.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,713.98	659.80

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	319,989.56	ADJUSTMENTS	5,513.30
COVERED CHARGES	313,545.37	CONTRACTUAL ALLOW	220,895.98
NON-COVERD CHARGES	6,444.19	TOTAL MEDICAID LIAB	92,649.39
		LESS: COB	0.00
		LESS: COPAYMENT	189.89
		REIMBURSEMENT	92,459.50
		TOTAL NUMBER OF CLAIMS	17

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,741.98	377.77	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	136,191.26	2,353.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,126.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,956.25	64.43
EKG/ECG	0.00	205.75	MRI SERVICES	0.00	0.00
IV THERAPY	320.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	42,248.63	2,844.49	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	55,398.00	199.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,100.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,336.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	15,425.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	451.50	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	30,249.75	399.00			
			TOTAL ANCILLARY	313,545.37	6,444.19
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	313,545.37	6,444.19

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
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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	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SYLVAN GROVE HOSPITAL
 1050 MCDONOUGH RD
 JACKSON,GA 30233-1524

PROVIDER NUMBER 000001856A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	115,896.35	ADJUSTMENTS	10,184.59
COVERED CHARGES	111,537.47	CONTRACTUAL ALLOW	90,435.30
NON-COVERD CHARGES	4,358.88	TOTAL MEDICAID LIAB	21,102.17
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	21,102.17

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	18		0	17,766.00		4,358.88
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	18		0	17,766.00		4,358.88
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	18		0	17,766.00		4,358.88

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

SYLVAN GROVE HOSPITAL
 1050 MCDONOUGH RD
 JACKSON,GA 30233-1524

PROVIDER NUMBER
 000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,224.36	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	17,102.88	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	13,821.24	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,255.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	928.16	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	16,419.70	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	10,800.49	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	219.64	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	93,771.47	0.00
			TOTAL ACCOMODATIONS	17,766.00	4,358.88
			TOTAL CHARGES	111,537.47	4,358.88

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,634,476.56	ADJUSTMENTS	60,574.42
COVERED CHARGES	2,378,977.71	CONTRACTUAL ALLOW	2,029,218.71
NON-COVERD CHARGES	255,498.85	TOTAL MEDICAID LIAB	349,759.00
		LESS: COB	56.25
		LESS: COPAYMENT	372.00
		REIMBURSEMENT	349,330.75
		ALL OTHER	326,535.85
		FEE SCHEDULE-LAB	20,070.63
		INJECTABLE DRUGS	2,724.27
		TOTAL NUMBER OF CLAIMS	1,174

SYLVAN GROVE HOSPITAL
 1050 MCDONOUGH RD
 JACKSON,GA 30233-1524

PROVIDER NUMBER
 000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	60,595.21	1,204.99	OTHER LAB	13,963.44	0.00
MED/SURG SUPPLY	39,940.15	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	210,924.81	1,348.18	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	324,331.57	99,904.13	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,292.00	3,537.10	FEE SCHEDULE LAB	371,605.86	110,339.30
EKG/ECG	48,066.00	1,392.24	MRI SERVICES	0.00	0.00
IV THERAPY	102,936.37	5,581.58	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	185.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	32,620.56	4,532.57	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,026,543.31	2,094.47	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	129,058.73	23,986.50
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	1,469.10	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,339.70	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	108.69			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,575.00	0.00			
			TOTAL ANCILLARY	2,378,977.71	255,498.85
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,378,977.71	255,498.85

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,061.26	ADJUSTMENTS	0.00
COVERED CHARGES	2,957.32	CONTRACTUAL ALLOW	1,938.91
NON-COVERD CHARGES	103.94	TOTAL MEDICAID LIAB	1,018.41
		LESS: COB	1,018.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SYLVAN GROVE HOSPITAL
 1050 MCDONOUGH RD
 JACKSON,GA 30233-1524

PROVIDER NUMBER
 000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	64.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	458.60	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,156.48	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	272.14	103.94
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	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,957.32	103.94
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,957.32	103.94

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	270,706.58	ADJUSTMENTS	235.00
COVERED CHARGES	266,898.18	CONTRACTUAL ALLOW	254,398.18
NON-COVERD CHARGES	3,808.40	TOTAL MEDICAID LIAB	12,500.00
		LESS: COB	2.02
		LESS: COPAYMENT	531.00
		REIMBURSEMENT	11,966.98
		TOTAL NUMBER OF CLAIMS	250

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

SYLVAN GROVE HOSPITAL
 1050 MCDONOUGH RD
 JACKSON,GA 30233-1524

PROVIDER NUMBER
 000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,630.90	2.43	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,634.47	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,089.13	503.08	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,163.44	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	18,848.43	2,671.74
EKG/ECG	1,782.24	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,588.13	120.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	203.75	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	193,886.32	94.35	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,071.37	416.80
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	266,898.18	3,808.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	266,898.18	3,808.40

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,335.35	ADJUSTMENTS	0.00
COVERED CHARGES	1,335.35	CONTRACTUAL ALLOW	1,023.27
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	312.08
		LESS: COB	312.08
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SYLVAN GROVE HOSPITAL
 1050 MCDONOUGH RD
 JACKSON,GA 30233-1524

PROVIDER NUMBER
 000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16.65	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	343.95	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	585.08	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	389.67	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,335.35	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,335.35	0.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SYLVAN GROVE HOSPITAL
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,225,720.63	ADJUSTMENTS	581,090.20
COVERED CHARGES	16,054,664.32	CONTRACTUAL ALLOW	11,395,306.17
NON-COVERD CHARGES	171,056.31	TOTAL MEDICAID LIAB	4,659,358.15
		LESS: COB	41,208.28
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,618,149.87

TOTAL NUMBER OF ADMISSIONS 609

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,165		0	1,144,414.00		29,557.00
ROUTINE NURSERY	255		2	153,750.00		1,200.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,420		2	1,298,164.00		30,757.00
SPECIAL CARE SERVICES						
CCU	828		0	1,310,495.00		0.00
ICU	258		0	620,490.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,086		0	1,930,985.00		0.00
TOTAL ACCOMODATIONS	2,506		2	3,229,149.00		30,757.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,799,135.52	11,127.94	OTHER LAB	131,789.87	1,118.00
MED/SURG SUPPLY	1,122,724.15	12,086.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,211,463.00	9,888.00	EDUCATION & TRAINING	5,158.00	260.00
RADIOLOGY-DIAGNOSTIC	207,529.00	286.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	582,979.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	99,387.86	948.04	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	134,718.00	0.00	MRI SERVICES	142,998.00	0.00
IV THERAPY	120,278.00	10,033.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,066,766.50	7,540.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	345,020.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	940,946.00	17,347.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	152,706.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	74,058.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	469,077.00	2,002.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	16,210.33
LABORATORY PATHOLOGIC	33,029.00	0.00	INJECTABLE DRUGS	785,740.80	0.00
RADIOLOGY THERAPEUTIC	100,901.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	26,509.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	7,488.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	103,869.00	31,926.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	12,292.00	1,271.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	577,440.62	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	48,147.00	5,484.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	201,651.00	9,087.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	151,292.00	1,116.00			
AUDIOLOGY	8,585.00	0.00			
CARDIOLOGY	1,069,512.00	2,390.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,786.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	84,539.00	179.00			
			TOTAL ANCILLARY	12,825,515.32	140,299.31
			TOTAL ACCOMODATIONS	3,229,149.00	30,757.00
			TOTAL CHARGES	16,054,664.32	171,056.31

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	54,318.80	ADJUSTMENTS	0.00
COVERED CHARGES	40,045.80	CONTRACTUAL ALLOW	16,830.48
NON-COVERD CHARGES	14,273.00	TOTAL MEDICAID LIAB	23,215.32
		LESS: COB	23,215.32
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	10		0	4,893.00		5,085.00
ROUTINE NURSERY	0		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	4,893.00		5,085.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	4,893.00		5,085.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,735.90	1,602.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,536.90	341.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,962.00	1,740.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,937.00	4,101.00	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	812.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,744.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	14,578.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	930.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,350.00	1,129.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	567.00	275.00			
			TOTAL ANCILLARY	35,152.80	9,188.00
			TOTAL ACCOMODATIONS	4,893.00	5,085.00
			TOTAL CHARGES	40,045.80	14,273.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
Run Time: 00:34:40
Page: 5

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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,919,630.75	ADJUSTMENTS	613,699.49
COVERED CHARGES	16,037,977.23	CONTRACTUAL ALLOW	12,387,512.98
NON-COVERD CHARGES	881,653.52	TOTAL MEDICAID LIAB	3,650,464.25
		LESS: COB	1,318.95
		LESS: COPAYMENT	9,939.78
		REIMBURSEMENT	3,639,205.52
		ALL OTHER	3,281,571.85
		FEE SCHEDULE-LAB	158,446.90
		INJECTABLE DRUGS	199,186.77

TOTAL NUMBER OF CLAIMS 6,399

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	587,436.02	10,613.89	OTHER LAB	136,679.18	300.00
MED/SURG SUPPLY	503,798.29	81.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	150.00	785.00
RADIOLOGY-DIAGNOSTIC	656,268.00	6,210.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,992,270.00	62,090.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	285.00	4,562.00	FEE SCHEDULE LAB	1,959,868.60	302,793.10
EKG/ECG	190,449.00	6,507.00	MRI SERVICES	860,171.00	10,800.00
IV THERAPY	686,320.00	43,246.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,128,631.26	145,327.74	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	21,884.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	83,422.00	8,080.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	256,890.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	132,545.34	11,064.66	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,341,082.00	6,802.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	100.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	743.60
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	819,416.67	111,651.53
RADIOLOGY THERAPEUTIC	564,469.00	11,027.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	578.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,110.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	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	251,134.00	40,266.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	752,015.00	5,445.00	IMPL DEV CHARGE PATIENTS	77,236.87	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,920.00
OTHER IMAGING SERVICE	520,979.00	58,940.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	47,379.00	647.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	390,639.00	0.00			
AUDIOLOGY	0.00	85.00			
CARDIOLOGY	544,662.00	16,991.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	92,364.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	439,433.00	6,191.00			
			TOTAL ANCILLARY	16,037,977.23	881,653.52
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,037,977.23	881,653.52

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
Run Time: 00:34:40
Page: 7

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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014001004616	11/04/13 - 11/04/13	01/06/14	0.00	365.00	0.00	0.00	0.00
905	2014001004616	11/05/13 - 11/05/13	01/06/14	0.00	365.00	0.00	0.00	0.00
905	2014001004616	11/06/13 - 11/06/13	01/06/14	0.00	365.00	0.00	0.00	0.00
905	2014001004616	11/07/13 - 11/07/13	01/06/14	0.00	365.00	0.00	0.00	0.00
905	2014001004616	11/08/13 - 11/08/13	01/06/14	0.00	365.00	0.00	0.00	0.00
905	2014101054178	03/04/14 - 03/04/14	04/14/14	0.00	365.00	0.00	0.00	0.00
905	2014101054178	03/05/14 - 03/05/14	04/14/14	0.00	365.00	0.00	0.00	0.00
905	2014101054178	03/06/14 - 03/06/14	04/14/14	0.00	365.00	0.00	0.00	0.00
TOTAL				0.00	2,920.00	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

Run Date: 07/15/2015
Run Time: 00:35:14
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	145,001.08	ADJUSTMENTS	0.00
COVERED CHARGES	88,162.15	CONTRACTUAL ALLOW	12,749.00
NON-COVERD CHARGES	56,838.93	TOTAL MEDICAID LIAB	75,413.15
		LESS: COB	75,377.15
		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

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,586.05	907.55	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,401.65	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,238.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,926.00	7,975.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	14,351.00	1,202.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,740.00	585.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,582.00	13,166.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	546.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	438.00	424.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	798.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,422.00	172.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,895.45	1,747.38
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	2,661.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	605.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	3,397.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	4,015.00
OTHER IMAGING SERVICE	1,530.00	1,392.00			
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	0.00	17,600.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	103.00	1,595.00			
			TOTAL ANCILLARY	88,162.15	56,838.93
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	88,162.15	56,838.93

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014176021018	04/24/14 - 04/24/14	06/30/14	0.00	365.00	0.00	1,452.00	0.00
905	2014176021018	04/25/14 - 04/25/14	06/30/14	0.00	365.00	0.00	1,452.00	0.00
905	2014176021018	04/28/14 - 04/28/14	06/30/14	0.00	365.00	0.00	1,452.00	0.00
905	2014176021018	04/30/14 - 04/30/14	06/30/14	0.00	365.00	0.00	1,452.00	0.00
905	2014176021018	05/02/14 - 05/02/14	06/30/14	0.00	365.00	0.00	1,452.00	0.00
905	2014176021018	05/05/14 - 05/05/14	06/30/14	0.00	365.00	0.00	1,452.00	0.00
905	2014176021018	05/07/14 - 05/07/14	06/30/14	0.00	365.00	0.00	1,452.00	0.00
905	2014176021018	05/09/14 - 05/09/14	06/30/14	0.00	365.00	0.00	1,452.00	0.00
905	2014176021018	05/12/14 - 05/12/14	06/30/14	0.00	365.00	0.00	1,452.00	0.00
905	2014176021018	05/14/14 - 05/14/14	06/30/14	0.00	365.00	0.00	1,452.00	0.00
905	2014176021018	05/16/14 - 05/16/14	06/30/14	0.00	365.00	0.00	1,452.00	0.00
TOTAL				0.00	4,015.00	0.00	15,972.00	0.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,068,229.08	ADJUSTMENTS	886.92
COVERED CHARGES	1,030,514.08	CONTRACTUAL ALLOW	987,887.82
NON-COVERD CHARGES	37,715.00	TOTAL MEDICAID LIAB	42,626.26
		LESS: COB	0.00
		LESS: COPAYMENT	1,690.93
		REIMBURSEMENT	40,935.33
		TOTAL NUMBER OF CLAIMS	762

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,664.17	200.00	OTHER LAB	3,788.00	0.00
MED/SURG SUPPLY	11,122.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	46,106.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	61,979.00	18,000.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	132,516.00	12,811.00
EKG/ECG	13,496.00	0.00	MRI SERVICES	15,264.00	0.00
IV THERAPY	45,297.00	297.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,493.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	493.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,322.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,728.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	385,349.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	46,307.91	140.00
RADIOLOGY THERAPEUTIC	199,254.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	235.00	53.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	775.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,249.00	6,214.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,968.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,653.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,455.00	0.00			
			TOTAL ANCILLARY	1,030,514.08	37,715.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,030,514.08	37,715.00

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,120.31	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	123.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,823.00	1,823.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,271.00	42.00
EKG/ECG	241.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,923.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,590.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	24,046.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	35,137.31	1,865.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	35,137.31	1,865.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII

Run Date: 07/15/2015
Run Time: 00:35:22
Page: 15

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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,748,884.96	ADJUSTMENTS	211,069.02
COVERED CHARGES	3,406,225.62	CONTRACTUAL ALLOW	2,840,405.31
NON-COVERD CHARGES	342,659.34	TOTAL MEDICAID LIAB	565,820.31
		LESS: COB	0.00
		LESS: COPAYMENT	1,428.00
		REIMBURSEMENT	564,392.31

TOTAL NUMBER OF CLAIMS 102

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	178,756.03	2,890.46	OTHER LAB	5,910.74	0.00
MED/SURG SUPPLY	142,928.24	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	195.00
RADIOLOGY-DIAGNOSTIC	17,095.00	514.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,368.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	392.00	4,954.00	FEE SCHEDULE LAB	75,031.00	15,261.00
EKG/ECG	9,399.00	2,892.00	MRI SERVICES	7,746.00	0.00
IV THERAPY	119,623.00	6,041.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	249,421.61	27,721.89	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,231.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	27,678.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,966.00	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	1,081,635.55	186,627.99
RADIOLOGY THERAPEUTIC	750,697.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,579.00	265.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	44,165.00	0.00	IMPL DEV CHARGE PATIENTS	282,683.45	10,597.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,174.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,549.00	647.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	31,263.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	226,795.00	82,265.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	112,139.00	1,788.00			
			TOTAL ANCILLARY	3,406,225.62	342,659.34
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,406,225.62	342,659.34

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
 Run Time: 00:35:32
 Page: 1

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,836,595.14	ADJUSTMENTS	394,841.85
COVERED CHARGES	4,613,469.22	CONTRACTUAL ALLOW	4,164,042.98
NON-COVERD CHARGES	223,125.92	TOTAL MEDICAID LIAB	449,426.24
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	449,426.24

TOTAL NUMBER OF ADMISSIONS 51

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	98		0	73,402.00		223,125.92
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	98		0	73,402.00		223,125.92
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	98		0	73,402.00		223,125.92

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
 Run Time: 00:35:32
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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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	95,765.16	0.00	OTHER LAB	1,969.26	0.00
MED/SURG SUPPLY	26,555.07	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	38,741.50	0.00	EDUCATION & TRAINING	811.24	0.00
RADIOLOGY-DIAGNOSTIC	33,834.38	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,733.83	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	18,215.40	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,163.80	0.00	MRI SERVICES	1,948.38	0.00
IV THERAPY	6,849.24	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,041,721.60	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,590.94	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,000.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,806.53	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	393.36	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,231.25	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	1,220,487.06	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,056.90	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	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	3,095.44	0.00			
			TOTAL ANCILLARY	4,540,067.22	0.00
			TOTAL ACCOMODATIONS	73,402.00	223,125.92
			TOTAL CHARGES	4,613,469.22	223,125.92

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
 Run Time: 00:35:33
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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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	260,567.88	ADJUSTMENTS	0.00
COVERED CHARGES	250,065.88	CONTRACTUAL ALLOW	144,390.41
NON-COVERD CHARGES	10,502.00	TOTAL MEDICAID LIAB	105,675.47
		LESS: COB	105,675.47
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2		2	1,498.00		10,502.00
ROUTINE NURSERY	0		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		2	1,498.00		10,502.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	2		2	1,498.00		10,502.00

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,454.43	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	446.44	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	34.80	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,500.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	749.70	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	46,515.20	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,867.31	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	188,000.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	248,567.88	0.00
			TOTAL ACCOMODATIONS	1,498.00	10,502.00
			TOTAL CHARGES	250,065.88	10,502.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
Run Time: 00:35:34
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,334,175.88	ADJUSTMENTS	258,980.23
COVERED CHARGES	6,962,704.55	CONTRACTUAL ALLOW	5,858,352.69
NON-COVERD CHARGES	371,471.33	TOTAL MEDICAID LIAB	1,104,351.86
		LESS: COB	2,702.95
		LESS: COPAYMENT	3,423.00
		REIMBURSEMENT	1,098,225.91
		ALL OTHER	1,048,300.62
		FEE SCHEDULE-LAB	49,881.05
		INJECTABLE DRUGS	44.24
		TOTAL NUMBER OF CLAIMS	2,169

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	118,425.47	1,671.75	OTHER LAB	72,688.34	1,496.88
MED/SURG SUPPLY	17,428.38	97.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	47.72
RADIOLOGY-DIAGNOSTIC	238,112.48	27,081.66	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	217,198.59	25,841.55	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,091.22	1,702.32	FEE SCHEDULE LAB	474,706.83	134,089.14
EKG/ECG	20,697.45	581.90	MRI SERVICES	324,684.15	5,137.30
IV THERAPY	49,944.74	17,983.88	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,091,912.70	127,362.96	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	14,540.94	186.20	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,000.00	5,500.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	166,478.77	21,010.73	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,141.51	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	322.13	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	266.58	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	100,193.64	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	34,268.58	606.48			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,456.00	392.70			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,145.32	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,000.73	680.26			
			TOTAL ANCILLARY	6,962,704.55	371,471.33
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,962,704.55	371,471.33

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
Run Time: 00:35:41
Page: 7

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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	100,065.18	ADJUSTMENTS	0.00
COVERED CHARGES	37,137.90	CONTRACTUAL ALLOW	9,453.58
NON-COVERD CHARGES	62,927.28	TOTAL MEDICAID LIAB	27,684.32
		LESS: COB	27,654.32
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 17

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,896.33	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	24.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,274.46	3,900.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	214.29	1,044.96	FEE SCHEDULE LAB	3,330.40	343.92
EKG/ECG	172.45	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	95.28	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	28,819.20	57,638.40	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,311.49	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	37,137.90	62,927.28
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	37,137.90	62,927.28

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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Page: 9

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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	98,391.76	ADJUSTMENTS	97.00
COVERED CHARGES	91,177.06	CONTRACTUAL ALLOW	84,577.06
NON-COVERD CHARGES	7,214.70	TOTAL MEDICAID LIAB	6,600.00
		LESS: COB	0.00
		LESS: COPAYMENT	261.00
		REIMBURSEMENT	6,339.00
		TOTAL NUMBER OF CLAIMS	132

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,893.95	0.00	OTHER LAB	1,280.52	0.00
MED/SURG SUPPLY	1,248.63	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	227.04	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,250.66	132.18	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,115.84	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,844.47	3,392.57
EKG/ECG	632.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,260.88	3,120.15	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	439.38	342.76	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	36,195.43	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,838.22	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,177.08	0.00			
			TOTAL ANCILLARY	91,177.06	7,214.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	91,177.06	7,214.70

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,651.66	ADJUSTMENTS	0.00
COVERED CHARGES	2,947.20	CONTRACTUAL ALLOW	1,562.46
NON-COVERD CHARGES	1,704.46	TOTAL MEDICAID LIAB	1,384.74
		LESS: COB	1,381.74
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	234.62	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	70.55	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	309.24	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,503.81	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	606.80	200.65
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	190.56	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	958.65	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	576.78	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,947.20	1,704.46
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,947.20	1,704.46

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII

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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,503,880.72	ADJUSTMENTS	14,315.56
COVERED CHARGES	1,450,681.66	CONTRACTUAL ALLOW	1,312,097.34
NON-COVERD CHARGES	53,199.06	TOTAL MEDICAID LIAB	138,584.32
		LESS: COB	1,255.81
		LESS: COPAYMENT	78.00
		REIMBURSEMENT	137,250.51
		TOTAL NUMBER OF CLAIMS	28

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,281.86	570.09	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	13,347.42	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	8,400.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	294.57	FEE SCHEDULE LAB	1,824.04	48.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	893,283.36	34,886.40	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	443.49	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	9,000.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,336.95	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	515,208.18	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,956.36	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,450,681.66	53,199.06
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,450,681.66	53,199.06

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	221,266.42	ADJUSTMENTS	0.00
COVERED CHARGES	221,266.42	CONTRACTUAL ALLOW	120,436.14
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	100,830.28
		LESS: COB	100,827.28
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,260.02	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	34,886.40	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	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	185,120.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	221,266.42	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	221,266.42	0.00

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,521,021.37	ADJUSTMENTS	314,329.83
COVERED CHARGES	25,791,925.17	CONTRACTUAL ALLOW	19,563,193.89
NON-COVERD CHARGES	729,096.20	TOTAL MEDICAID LIAB	6,228,731.28
		LESS: COB	19,124.85
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,209,606.43

TOTAL NUMBER OF ADMISSIONS 871

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,153		0	2,162,970.00		227,850.00
ROUTINE NURSERY	360		0	221,305.00		59,725.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,513		0	2,384,275.00		287,575.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	753		0	1,271,060.00		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	17		0	23,800.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	770		0	1,294,860.00		0.00
TOTAL ACCOMODATIONS	4,283		0	3,679,135.00		287,575.00

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,213,210.44	646.66	OTHER LAB	134,272.50	0.00
MED/SURG SUPPLY	1,626,991.37	8,636.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,834,234.24	0.00	EDUCATION & TRAINING	1,297.00	0.00
RADIOLOGY-DIAGNOSTIC	543,654.54	0.00	OTHER THERAPEUTIC SVC	0.00	22,655.00
CT SCAN	1,089,192.37	5,178.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	172,380.63	195.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	612,121.10	0.00	MRI SERVICES	279,820.75	0.00
IV THERAPY	122,918.75	0.00	PROFESSIONAL FEES	0.00	13,242.03
OPERATING ROOM	1,728,835.47	16,536.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	142,864.50	0.00	REHAB THERAPY	729.00	0.00
RESPIRATORY SERVICES	1,026,137.17	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	36,979.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	177,327.25	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	813,422.09	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	187,085.90	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	111,309.50	0.00	INJECTABLE DRUGS	2,393,255.77	0.00
RADIOLOGY THERAPEUTIC	65,722.25	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	35,441.81	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	11,566.23	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	67,637.50	8,005.00	PATIENT CONVENIENCE	0.00	138,469.67
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	15,348.10	1,691.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	867,533.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	143,022.00	6,604.50			
BLOOD	203.00	0.00			
BLOOD STORAGE & PRO.	347,675.22	211,288.84			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	109,400.75	8,372.50			
AUDIOLOGY	30,492.00	0.00			
CARDIOLOGY	789,379.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	18,463.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	362,866.22	0.00			
			TOTAL ANCILLARY	22,112,790.17	441,521.20
			TOTAL ACCOMODATIONS	3,679,135.00	287,575.00
			TOTAL CHARGES	25,791,925.17	729,096.20

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	329,698.94	ADJUSTMENTS	0.00
COVERED CHARGES	310,150.94	CONTRACTUAL ALLOW	45,919.54
NON-COVERD CHARGES	19,548.00	TOTAL MEDICAID LIAB	264,231.40
		LESS: COB	264,231.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 10

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	58		0	30,820.00		3,480.00
ROUTINE NURSERY	1		0	700.00		630.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	59		0	31,520.00		4,110.00
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	59		0	31,520.00		4,110.00

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,167.85	0.00	OTHER LAB	7,517.00	0.00
MED/SURG SUPPLY	7,698.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	24,211.25	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	892.00	0.00	OTHER THERAPEUTIC SVC	0.00	241.50
CT SCAN	5,277.75	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	911.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,096.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,724.25	0.00	PROFESSIONAL FEES	0.00	13,406.00
OPERATING ROOM	48,224.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,966.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	618.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,561.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,085.73	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,402.50	0.00	INJECTABLE DRUGS	8,041.78	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	50.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	105,973.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,013.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,852.25	1,790.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,471.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	874.58	0.00			
			TOTAL ANCILLARY	278,630.94	15,438.00
			TOTAL ACCOMODATIONS	31,520.00	4,110.00
			TOTAL CHARGES	310,150.94	19,548.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
Run Time: 00:36:01
Page: 5

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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,830,028.53	ADJUSTMENTS	325,407.31
COVERED CHARGES	21,118,729.95	CONTRACTUAL ALLOW	17,249,202.03
NON-COVERD CHARGES	5,711,298.58	TOTAL MEDICAID LIAB	3,869,527.92
		LESS: COB	3,013.44
		LESS: COPAYMENT	17,059.88
		REIMBURSEMENT	3,849,454.60
		ALL OTHER	3,118,575.71
		FEE SCHEDULE-LAB	443,690.31
		INJECTABLE DRUGS	287,188.58

TOTAL NUMBER OF CLAIMS 10,145

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,144,224.21	507,333.30	OTHER LAB	684,499.75	879.50
MED/SURG SUPPLY	748,620.69	160,773.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	135.50	EDUCATION & TRAINING	2,566.50	390.00
RADIOLOGY-DIAGNOSTIC	882,398.33	26,159.07	OTHER THERAPEUTIC SVC	0.00	100,117.00
CT SCAN	2,316,205.25	357,290.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,279.50	17,034.75	FEE SCHEDULE LAB	4,425,224.40	1,259,345.16
EKG/ECG	277,895.54	55,256.82	MRI SERVICES	752,294.25	51,801.75
IV THERAPY	519,712.99	90,139.69	PROFESSIONAL FEES	0.00	58,512.25
OPERATING ROOM	1,757,116.59	414,166.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	28,938.75	0.00	REHAB THERAPY	970.00	2,916.00
RESPIRATORY SERVICES	114,109.00	27,101.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	110,445.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	393,382.25	94,447.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,245,861.50	60,970.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	345,425.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	699.00	INJECTABLE DRUGS	1,581,424.52	1,368,781.79
RADIOLOGY THERAPEUTIC	423,673.50	972.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,781.50	2,259.09	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,413.75	1,732.83	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	64,457.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	87,914.50	4,383.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	43,088.00	550,358.73
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	729,611.50	74,028.59			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	97,059.00	37,494.25			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	411,220.57	68,824.26			
AUDIOLOGY	2,232.50	4,142.75			
CARDIOLOGY	535,879.25	233,391.25			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	19,689.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	427,572.36	15,002.75			
			TOTAL ANCILLARY	21,118,729.95	5,711,298.58
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	21,118,729.95	5,711,298.58

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	466,430.11	ADJUSTMENTS	0.00
COVERED CHARGES	298,929.02	CONTRACTUAL ALLOW	67,141.55
NON-COVERD CHARGES	167,501.09	TOTAL MEDICAID LIAB	231,787.47
		LESS: COB	231,603.18
		LESS: COPAYMENT	184.29
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 198

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,742.61	11,636.45	OTHER LAB	7,159.00	0.00
MED/SURG SUPPLY	11,931.50	426.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,263.00	0.00	OTHER THERAPEUTIC SVC	0.00	1,212.25
CT SCAN	17,262.75	30,476.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	76,223.00	28,161.75
EKG/ECG	5,444.25	213.50	MRI SERVICES	11,168.00	0.00
IV THERAPY	5,582.75	602.75	PROFESSIONAL FEES	0.00	31,811.25
OPERATING ROOM	10,501.25	3,895.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	354.75	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	823.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,956.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,114.75	12,256.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	49,119.75	4,779.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,279.51	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,526.33	32,186.61
RADIOLOGY THERAPEUTIC	7,242.50	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	599.53	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,047.50	184.75	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	18,657.25	2,300.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,708.75	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,411.75	1,773.75			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	10,122.25	4,852.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,285.82	131.50			
			TOTAL ANCILLARY	298,929.02	167,501.09
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	298,929.02	167,501.09

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,233,550.43	ADJUSTMENTS	797.10
COVERED CHARGES	1,100,289.76	CONTRACTUAL ALLOW	1,046,635.18
NON-COVERD CHARGES	133,260.67	TOTAL MEDICAID LIAB	53,654.58
		LESS: COB	49.47
		LESS: COPAYMENT	1,884.00
		REIMBURSEMENT	51,721.11
		TOTAL NUMBER OF CLAIMS	961

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,827.47	25,989.25	OTHER LAB	7,701.75	0.00
MED/SURG SUPPLY	19,674.50	5,931.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	78,426.75	541.50	OTHER THERAPEUTIC SVC	0.00	1,932.00
CT SCAN	72,090.25	13,368.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	788.56	FEE SCHEDULE LAB	263,950.57	31,636.25
EKG/ECG	14,413.75	221.75	MRI SERVICES	6,757.50	11,257.75
IV THERAPY	20,142.00	2,561.25	PROFESSIONAL FEES	0.00	9,721.25
OPERATING ROOM	8,044.75	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,602.00	673.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	128.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	490,558.00	3,436.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	894.88	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	46,338.74	13,279.86
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	125.00	95.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	21,279.50	11,568.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,207.25	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,997.50	129.75			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,257.60	0.00			
			TOTAL ANCILLARY	1,100,289.76	133,260.67
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,100,289.76	133,260.67

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	57,681.21	ADJUSTMENTS	0.00
COVERED CHARGES	47,290.26	CONTRACTUAL ALLOW	20,590.54
NON-COVERD CHARGES	10,390.95	TOTAL MEDICAID LIAB	26,699.72
		LESS: COB	26,666.72
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	23

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,374.88	680.45	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	825.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,238.50	213.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,722.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	16,182.50	2,058.75
EKG/ECG	1,108.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,044.00	0.00	PROFESSIONAL FEES	0.00	6,036.75
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	272.25	123.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	17,318.75	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	719.75	504.75
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	2,322.75	774.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	315.75	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	844.88	0.00			
			TOTAL ANCILLARY	47,290.26	10,390.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	47,290.26	10,390.95

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,664,819.23	ADJUSTMENTS	120,742.46
COVERED CHARGES	3,249,927.92	CONTRACTUAL ALLOW	2,774,153.05
NON-COVERD CHARGES	414,891.31	TOTAL MEDICAID LIAB	475,774.87
		LESS: COB	0.00
		LESS: COPAYMENT	830.07
		REIMBURSEMENT	474,944.80
		TOTAL NUMBER OF CLAIMS	87

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	141,523.11	37,921.00	OTHER LAB	959.50	0.00
MED/SURG SUPPLY	72,201.00	47,045.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,102.00	7,585.00	OTHER THERAPEUTIC SVC	0.00	14,580.75
CT SCAN	14,291.75	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	290.53	FEE SCHEDULE LAB	55,930.50	45,991.75
EKG/ECG	1,774.00	3,038.50	MRI SERVICES	0.00	0.00
IV THERAPY	28,955.00	603.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	266,369.25	23,598.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	243.00
RESPIRATORY SERVICES	2,292.00	129.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,248.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,990.25	425.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	17,674.44	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,079,832.78	150,740.00
RADIOLOGY THERAPEUTIC	317,042.00	731.50	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	195.03	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	17,562.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,752.50	679.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	156,713.50	41,758.25
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,038.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,697.75	8,057.25			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	13,890.00	2,040.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	17,647.50	11,674.50			
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	14,002.59	0.00			
			TOTAL ANCILLARY	3,249,927.92	414,891.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,249,927.92	414,891.31

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
Run Time: 00:36:48
Page: 15

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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	61,472.50	ADJUSTMENTS	0.00
COVERED CHARGES	60,741.00	CONTRACTUAL ALLOW	6,782.20
NON-COVERD CHARGES	731.50	TOTAL MEDICAID LIAB	53,958.80
		LESS: COB	53,895.80
		LESS: COPAYMENT	63.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20,713.25	0.00
RADIOLOGY THERAPEUTIC	39,527.75	731.50	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	500.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	60,741.00	731.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	60,741.00	731.50

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE I
 INPATIENT PAID CLAIMS

Run Date: 07/15/2015
 Run Time: 00:36:57
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CHATUGE REGIONAL HOSPITAL
 PO BOX 509
 HIAWASSEE,GA 30546-0509

PROVIDER NUMBER 000001933A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	42,595.74	ADJUSTMENTS	0.00
COVERED CHARGES	41,695.74	CONTRACTUAL ALLOW	8,900.72
NON-COVERD CHARGES	900.00	TOTAL MEDICAID LIAB	32,795.02
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	32,795.02

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	10		0	7,500.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	10		0	7,500.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	10		0	7,500.00		0.00

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
 Run Time: 00:36:57
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

CHATUGE REGIONAL HOSPITAL
 PO BOX 509
 HIWASSEE,GA 30546-0509

PROVIDER NUMBER
 000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,566.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,522.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,604.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	380.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,700.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	165.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	395.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,700.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,604.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	725.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,311.00	900.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,523.74	0.00			
			TOTAL ANCILLARY	34,195.74	900.00
			TOTAL ACCOMODATIONS	7,500.00	0.00
			TOTAL CHARGES	41,695.74	900.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

CHATUGE REGIONAL HOSPITAL
PO BOX 509
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
Run Time: 00:36:58
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CHATUGE REGIONAL HOSPITAL
PO BOX 509
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	371,160.69	ADJUSTMENTS	5,670.42
COVERED CHARGES	312,305.31	CONTRACTUAL ALLOW	201,106.86
NON-COVERD CHARGES	58,855.38	TOTAL MEDICAID LIAB	111,198.45
		LESS: COB	0.00
		LESS: COPAYMENT	588.00
		REIMBURSEMENT	110,610.45
		ALL OTHER	96,599.41
		FEE SCHEDULE-LAB	13,494.63
		INJECTABLE DRUGS	516.41

TOTAL NUMBER OF CLAIMS 437

CHATUGE REGIONAL HOSPITAL
 PO BOX 509
 HIWASSEE,GA 30546-0509

PROVIDER NUMBER
 000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,504.00	3,457.00	OTHER LAB	8,595.00	0.00
MED/SURG SUPPLY	5,399.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	33,375.00	1,725.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	35,000.00	13,075.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	92,147.85	20,470.00
EKG/ECG	6,388.00	165.00	MRI SERVICES	9,425.00	4,975.00
IV THERAPY	0.00	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	1,045.00	1,060.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,522.00	2,476.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	77,245.46	4,124.42	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,775.00	3,667.75
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	86.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,755.00	135.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,179.00	450.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,400.00	170.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	18,000.00	175.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,550.00	2,319.21			
			TOTAL ANCILLARY	312,305.31	58,855.38
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	312,305.31	58,855.38

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

Run Date: 07/15/2015
Run Time: 00:37:01
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHATUGE REGIONAL HOSPITAL
PO BOX 509
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,313.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,305.00	CONTRACTUAL ALLOW	574.09
NON-COVERD CHARGES	8.00	TOTAL MEDICAID LIAB	730.91
		LESS: COB	730.91
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHATUGE REGIONAL HOSPITAL
 PO BOX 509
 HIAWASSEE,GA 30546-0509

PROVIDER NUMBER
 000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 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	57.00	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	193.00	8.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	875.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	55.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,305.00	8.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,305.00	8.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
Run Time: 00:37:01
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CHATUGE REGIONAL HOSPITAL
PO BOX 509
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,268.42	ADJUSTMENTS	144.00
COVERED CHARGES	19,429.42	CONTRACTUAL ALLOW	17,529.42
NON-COVERD CHARGES	839.00	TOTAL MEDICAID LIAB	1,900.00
		LESS: COB	0.00
		LESS: COPAYMENT	75.00
		REIMBURSEMENT	1,825.00
		TOTAL NUMBER OF CLAIMS	38

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

CHATUGE REGIONAL HOSPITAL
 PO BOX 509
 HIAWASSEE,GA 30546-0509

PROVIDER NUMBER
 000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	836.00	213.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	74.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,050.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,174.00	411.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,120.42	50.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	175.00	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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	19,429.42	839.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	19,429.42	839.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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CHATUGE REGIONAL HOSPITAL
PO BOX 509
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER
000001933A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/13	THROUGH	04/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHATUGE REGIONAL HOSPITAL
PO BOX 509
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER
000001933A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/13	THROUGH	04/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHATUGE REGIONAL HOSPITAL
PO BOX 509
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER
000001933A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/13	THROUGH	04/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

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 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	934,895.57	ADJUSTMENTS	3,942.36
COVERED CHARGES	919,945.57	CONTRACTUAL ALLOW	495,543.71
NON-COVERD CHARGES	14,950.00	TOTAL MEDICAID LIAB	424,401.86
		LESS: COB	6,244.92
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	418,156.94

TOTAL NUMBER OF ADMISSIONS 73

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	247		1	185,250.00		750.00
ROUTINE NURSERY	0		38	0.00		13,300.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	247		39	185,250.00		14,050.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	26		0	32,500.00		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	26		0	32,500.00		0.00
TOTAL ACCOMODATIONS	273		39	217,750.00		14,050.00

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 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	318,818.50	0.00	OTHER LAB	4,900.00	0.00
MED/SURG SUPPLY	54,124.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	112,683.40	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,050.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	30,400.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,185.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,455.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,326.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	12,057.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	35,805.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	900.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	46,366.08	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,055.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	593.25	0.00	INJECTABLE DRUGS	6,753.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,450.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	600.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	43.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,632.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,975.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,506.00	900.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	2,720.00	0.00			
CARDIOLOGY	4,500.00	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	7,297.59	0.00			
			TOTAL ANCILLARY	702,195.57	900.00
			TOTAL ACCOMODATIONS	217,750.00	14,050.00
			TOTAL CHARGES	919,945.57	14,950.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

Run Date: 07/15/2015
 Run Time: 00:37:10
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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 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	33,510.25	ADJUSTMENTS	0.00
COVERED CHARGES	30,990.25	CONTRACTUAL ALLOW	8,994.20
NON-COVERD CHARGES	2,520.00	TOTAL MEDICAID LIAB	21,996.05
		LESS: COB	21,996.05
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	11		0	8,250.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	11		0	8,250.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	11		0	8,250.00		0.00

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 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,523.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,036.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,834.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	2,520.00
OPERATING ROOM	1,500.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,280.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	40.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	555.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	131.25	0.00	INJECTABLE DRUGS	2,841.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	22,740.25	2,520.00
			TOTAL ACCOMODATIONS	8,250.00	0.00
			TOTAL CHARGES	30,990.25	2,520.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
Run Time: 00:37:10
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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 05/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,013,763.31	ADJUSTMENTS	83,069.76
COVERED CHARGES	1,885,287.72	CONTRACTUAL ALLOW	1,407,603.80
NON-COVERD CHARGES	128,475.59	TOTAL MEDICAID LIAB	477,683.92
		LESS: COB	1,381.55
		LESS: COPAYMENT	1,479.00
		REIMBURSEMENT	474,823.37
		ALL OTHER	421,500.91
		FEE SCHEDULE-LAB	51,493.04
		INJECTABLE DRUGS	1,829.42
		TOTAL NUMBER OF CLAIMS	1,578

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 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	144,140.25	0.00	OTHER LAB	12,750.00	0.00
MED/SURG SUPPLY	81,289.60	306.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	141,770.00	1,110.00	OTHER THERAPEUTIC SVC	0.00	4,200.00
CT SCAN	300,200.00	10,250.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,605.00	122.00	FEE SCHEDULE LAB	328,069.80	54,153.80
EKG/ECG	27,555.00	990.00	MRI SERVICES	86,575.00	6,750.00
IV THERAPY	99,230.00	9,505.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	100,804.00	2,900.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	770.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,086.00	2,863.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	15,390.00	1,050.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	351,929.24	6,050.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,300.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	30,985.25	820.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,540.00	2.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,600.00	8.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	660.00	144.20	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	2,498.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,350.00
OTHER IMAGING SERVICE	50,249.00	3,384.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	20,057.00	11,250.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	28,550.00	6,235.00			
AUDIOLOGY	160.00	0.00			
CARDIOLOGY	13,484.00	175.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	27,538.58	1,359.59			
			TOTAL ANCILLARY	1,885,287.72	128,475.59
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,885,287.72	128,475.59

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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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 05/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014094075578	03/24/14 - 03/24/14	04/14/14	0.00	1,175.00	0.00	0.00	0.00
615	2014094075578	03/24/14 - 03/24/14	04/14/14	0.00	1,175.00	0.00	0.00	0.00
TOTAL				0.00	2,350.00	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
Run Time: 00:37:19
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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 05/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,943.45	ADJUSTMENTS	0.00
COVERED CHARGES	25,769.45	CONTRACTUAL ALLOW	12,505.67
NON-COVERD CHARGES	2,174.00	TOTAL MEDICAID LIAB	13,263.78
		LESS: COB	13,242.78
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 30

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 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,708.00	0.00	OTHER LAB	1,000.00	0.00
MED/SURG SUPPLY	3,233.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	990.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	250.00	0.00	FEE SCHEDULE LAB	3,333.45	94.00
EKG/ECG	0.00	0.00	MRI SERVICES	1,300.00	0.00
IV THERAPY	1,800.00	550.00	PROFESSIONAL FEES	0.00	990.00
OPERATING ROOM	1,732.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	330.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	56.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,925.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	650.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	380.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,932.00	450.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,150.00	90.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	25,769.45	2,174.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,769.45	2,174.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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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 05/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	139,445.21	ADJUSTMENTS	750.16
COVERED CHARGES	135,508.21	CONTRACTUAL ALLOW	123,816.75
NON-COVERD CHARGES	3,937.00	TOTAL MEDICAID LIAB	11,691.46
		LESS: COB	0.00
		LESS: COPAYMENT	390.01
		REIMBURSEMENT	11,301.45
		TOTAL NUMBER OF CLAIMS	209

Report : CLM-0808-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,187.00	0.00	OTHER LAB	600.00	0.00
MED/SURG SUPPLY	1,955.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,785.00	0.00	OTHER THERAPEUTIC SVC	0.00	150.00
CT SCAN	14,475.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	26,299.00	2,250.00
EKG/ECG	1,320.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,245.00	350.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	448.00	112.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	65,872.21	1,075.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,365.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	957.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	135,508.21	3,937.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	135,508.21	3,937.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 05/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	475.00	ADJUSTMENTS	0.00
COVERED CHARGES	475.00	CONTRACTUAL ALLOW	338.83
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	136.17
		LESS: COB	133.17
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	50.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	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	400.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	25.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	475.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	475.00	0.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
Run Time: 00:37:21
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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	05/01/13	THROUGH	04/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
Run Time: 00:37:22
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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	05/01/13	THROUGH	04/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
 Run Time: 00:37:29
 Page: 1

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	45,267,050.47	ADJUSTMENTS	1,065,547.52
COVERED CHARGES	44,722,313.18	CONTRACTUAL ALLOW	31,702,116.11
NON-COVERD CHARGES	544,737.29	TOTAL MEDICAID LIAB	13,020,197.07
		LESS: COB	166,730.93
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	12,853,466.14

TOTAL NUMBER OF ADMISSIONS 1,312

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,074		0	1,744,640.00		38,280.00
ROUTINE NURSERY	650		61	606,861.00		29,172.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,724		61	2,351,501.00		67,452.00
SPECIAL CARE SERVICES						
CCU	96		0	156,000.00		0.00
ICU	4,855		0	5,014,401.00		54,488.00
NICU	142		0	230,750.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	5,093		0	5,401,151.00		54,488.00
TOTAL ACCOMODATIONS	8,817		61	7,752,652.00		121,940.00

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,965,565.09	118,960.64	OTHER LAB	225,280.00	1,144.00
MED/SURG SUPPLY	6,137,683.29	74,474.04	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,214,682.38	19,171.91	EDUCATION & TRAINING	32,971.00	170.00
RADIOLOGY-DIAGNOSTIC	1,054,515.00	2,400.00	OTHER THERAPEUTIC SVC	61,098.93	8,112.00
CT SCAN	1,832,490.00	1,776.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	269,819.03	14,626.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	243,896.00	0.00	MRI SERVICES	419,973.00	0.00
IV THERAPY	249,496.00	2,088.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,461,861.00	2,531.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	153,573.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,047,183.00	1,481.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	219,800.00	442.00	AMBULANCE	0.00	0.00
GI SERVICES	236,244.00	2,242.00	CAST ROOM	213.00	0.00
EMERGENCY ROOM	936,298.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	201,778.00	1,569.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	187,982.98	382.70	INJECTABLE DRUGS	540.40	0.00
RADIOLOGY THERAPEUTIC	567.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	110,202.00	11,523.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	99,049.00	11,239.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	310,168.00	10,754.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	52,762.42	5,389.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,497,776.66	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	7,839.00
OTHER IMAGING SERVICE	185,628.00	39,372.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	552,913.00	8,634.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	201,485.00	64,342.00			
AUDIOLOGY	25,536.00	3,900.00			
CARDIOLOGY	1,308,523.00	658.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	36,459.00	572.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	435,649.00	7,005.00			
			TOTAL ANCILLARY	36,969,661.18	422,797.29
			TOTAL ACCOMODATIONS	7,752,652.00	121,940.00
			TOTAL CHARGES	44,722,313.18	544,737.29

Report : CLM-0800-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014190043111	02/17/14 - 03/04/14	07/14/14	0.00	2,613.00	0.00	0.00	0.00
615	2015014047753	09/07/14 - 09/08/14	01/19/15	0.00	2,613.00	0.00	0.00	0.00
615	2015147020766	12/24/14 - 12/30/14	06/08/15	0.00	2,613.00	0.00	0.00	0.00
TOTAL				0.00	7,839.00	0.00	0.00	0.00

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	919,522.16	ADJUSTMENTS	0.00
COVERED CHARGES	919,522.16	CONTRACTUAL ALLOW	395,992.17
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	523,529.99
		LESS: COB	523,529.99
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 34

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	82		0	47,560.00		0.00
ROUTINE NURSERY	153		0	181,780.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	235		0	229,340.00		0.00
SPECIAL CARE SERVICES						
CCU	1		0	1,625.00		0.00
ICU	17		0	16,541.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	18,166.00		0.00
TOTAL ACCOMODATIONS	253		0	247,506.00		0.00

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	199,268.79	0.00	OTHER LAB	496.00	0.00
MED/SURG SUPPLY	130,435.22	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	65,080.12	0.00	EDUCATION & TRAINING	78.00	0.00
RADIOLOGY-DIAGNOSTIC	13,983.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,758.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,110.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,310.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,112.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	75,478.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	35,736.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	35,751.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,679.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,400.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,972.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	7,761.42	0.00	INJECTABLE DRUGS	77.20	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,365.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	772.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,901.91	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	62,825.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	817.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	650.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	2,040.00	0.00			
CARDIOLOGY	5,448.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,711.00	0.00			
			TOTAL ANCILLARY	672,016.16	0.00
			TOTAL ACCOMODATIONS	247,506.00	0.00
			TOTAL CHARGES	919,522.16	0.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,704,616.65	ADJUSTMENTS	723,673.84
COVERED CHARGES	16,373,043.18	CONTRACTUAL ALLOW	13,161,919.33
NON-COVERD CHARGES	2,331,573.47	TOTAL MEDICAID LIAB	3,211,123.85
		LESS: COB	51,385.65
		LESS: COPAYMENT	10,627.59
		REIMBURSEMENT	3,149,110.61
		ALL OTHER	2,512,372.45
		FEE SCHEDULE-LAB	334,577.00
		INJECTABLE DRUGS	302,161.16

TOTAL NUMBER OF CLAIMS 9,937

UNIVERSITY HOSPITAL
 1350 WALTON WAY
 AUGUSTA,GA 30901-2612

PROVIDER NUMBER
 000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	749,199.34	611.51	OTHER LAB	263,977.00	0.00
MED/SURG SUPPLY	1,655,100.76	167,019.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	245.00	EDUCATION & TRAINING	1,054.00	3,145.00
RADIOLOGY-DIAGNOSTIC	811,706.00	8,458.00	OTHER THERAPEUTIC SVC	0.00	278.00
CT SCAN	1,683,964.00	342,779.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,090.00	6,937.00	FEE SCHEDULE LAB	2,152,024.14	347,304.56
EKG/ECG	271,159.00	7,598.00	MRI SERVICES	532,000.00	45,422.00
IV THERAPY	710,110.00	12,898.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	901,731.30	179,721.70	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	103,868.00	0.00	REHAB THERAPY	0.00	397.00
RESPIRATORY SERVICES	221,549.00	7,987.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	99,580.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	143,577.34	2,614.66	CAST ROOM	7,190.00	0.00
EMERGENCY ROOM	2,280,467.00	788.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	180,396.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,030,083.76	270,815.52
RADIOLOGY THERAPEUTIC	94,626.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	22,720.00	2,378.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,364.00	751.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	7,924.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	236,471.00	16,016.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	72,914.54	451,298.52
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	3,596.00
OTHER IMAGING SERVICE	421,666.00	56,088.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	63,880.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	409,241.00	173,890.00			
AUDIOLOGY	2,944.00	0.00			
CARDIOLOGY	810,286.00	191,396.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	11,440.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	418,664.00	23,217.00			
			TOTAL ANCILLARY	16,373,043.18	2,331,573.47
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,373,043.18	2,331,573.47

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
7212	5914070001545	02/16/14 - 02/16/14	03/17/14	0.00	543.00	0.00	0.00	0.00
615	2015140050474	10/08/14 - 10/08/14	05/25/15	0.00	3,053.00	0.00	0.00	0.00
TOTAL				0.00	3,596.00	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	408,579.35	ADJUSTMENTS	0.00
COVERED CHARGES	328,948.25	CONTRACTUAL ALLOW	195,815.12
NON-COVERD CHARGES	79,631.10	TOTAL MEDICAID LIAB	133,133.13
		LESS: COB	132,962.13
		LESS: COPAYMENT	171.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 140

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,392.42	0.00	OTHER LAB	3,530.00	0.00
MED/SURG SUPPLY	50,024.62	306.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	304.00
RADIOLOGY-DIAGNOSTIC	8,966.00	0.00	OTHER THERAPEUTIC SVC	0.00	34.00
CT SCAN	7,989.00	5,328.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	408.00	180.00	FEE SCHEDULE LAB	33,640.03	5,030.42
EKG/ECG	2,726.00	0.00	MRI SERVICES	6,670.00	0.00
IV THERAPY	12,823.00	1,206.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	33,099.00	3,379.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,194.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	271.00	755.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,205.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,242.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,752.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,886.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	44,787.78	36,918.18
RADIOLOGY THERAPEUTIC	7,013.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,234.00	1,023.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	434.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,471.40	4,668.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,206.00	6,679.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,802.00	588.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,020.00	3,973.00			
AUDIOLOGY	2,152.00	0.00			
CARDIOLOGY	2,971.00	5,451.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,281.00	1,566.00			
			TOTAL ANCILLARY	328,948.25	79,631.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	328,948.25	79,631.10

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	328,903.56	ADJUSTMENTS	688.22
COVERED CHARGES	315,704.80	CONTRACTUAL ALLOW	288,218.67
NON-COVERD CHARGES	13,198.76	TOTAL MEDICAID LIAB	27,486.13
		LESS: COB	657.07
		LESS: COPAYMENT	1,005.00
		REIMBURSEMENT	25,824.06
		TOTAL NUMBER OF CLAIMS	480

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,567.91	12.21	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,295.04	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,333.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,910.00	7,104.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	50,331.04	3,164.52
EKG/ECG	5,502.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	17,123.00	189.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	388.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	175,531.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,997.81	209.03
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,891.00	2,520.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,835.00	0.00			
			TOTAL ANCILLARY	315,704.80	13,198.76
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	315,704.80	13,198.76

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
Run Time: 00:38:25
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,476.04	ADJUSTMENTS	0.00
COVERED CHARGES	6,194.04	CONTRACTUAL ALLOW	2,411.98
NON-COVERD CHARGES	282.00	TOTAL MEDICAID LIAB	3,782.06
		LESS: COB	3,779.06
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	7

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	333.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	571.02	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	543.52	20.00
EKG/ECG	262.00	262.00	MRI SERVICES	0.00	0.00
IV THERAPY	961.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,065.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	210.50	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	6,194.04	282.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,194.04	282.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,807,459.54	ADJUSTMENTS	77,867.46
COVERED CHARGES	986,975.62	CONTRACTUAL ALLOW	755,322.03
NON-COVERD CHARGES	820,483.92	TOTAL MEDICAID LIAB	231,653.59
		LESS: COB	0.00
		LESS: COPAYMENT	267.00
		REIMBURSEMENT	231,386.59
		TOTAL NUMBER OF CLAIMS	41

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,026.94	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	52,550.63	68,483.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,175.00	11,372.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,207.95	751.00
EKG/ECG	4,192.00	262.00	MRI SERVICES	2,611.00	0.00
IV THERAPY	1,886.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	570,926.13	66,517.87	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	58,788.00	1,633.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,384.00	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	670.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	195,212.97	53,883.05
RADIOLOGY THERAPEUTIC	12,647.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,096.00	756.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	589,514.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	32,832.00	27,312.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,770.00	0.00			
			TOTAL ANCILLARY	986,975.62	820,483.92
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	986,975.62	820,483.92

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
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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	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
 Run Time: 00:38:39
 Page: 1

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,132,150.09	ADJUSTMENTS	275,350.64
COVERED CHARGES	8,038,766.44	CONTRACTUAL ALLOW	5,294,799.79
NON-COVERD CHARGES	93,383.65	TOTAL MEDICAID LIAB	2,743,966.65
		LESS: COB	19,652.78
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,724,313.87

TOTAL NUMBER OF ADMISSIONS 347

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	935		0	886,618.00		62,235.00
ROUTINE NURSERY	59		0	44,191.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	994		0	930,809.00		62,235.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	319		0	576,409.00		0.00
NICU	33		0	35,310.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	352		0	611,719.00		0.00
TOTAL ACCOMODATIONS	1,346		0	1,542,528.00		62,235.00

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	474,300.79	110.50	OTHER LAB	14,758.00	0.00
MED/SURG SUPPLY	527,114.70	7,101.15	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	930,436.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	190,005.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	441,517.00	8,396.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	183,367.29	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	65,086.00	0.00	MRI SERVICES	51,597.00	0.00
IV THERAPY	197,649.00	2,288.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	974,080.00	2,243.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	93,832.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	541,347.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	45,810.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	65,132.00	4,161.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	334,978.00	702.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	149,453.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	42,975.00	0.00	INJECTABLE DRUGS	613,763.16	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	11,385.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,167.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	18,378.00	0.00	PATIENT CONVENIENCE	0.00	25.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,750.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	204,477.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	40,506.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	122,179.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	22,075.00	4,137.00			
AUDIOLOGY	3,444.00	1,985.00			
CARDIOLOGY	89,554.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	960.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	37,162.00	0.00			
			TOTAL ANCILLARY	6,496,238.44	31,148.65
			TOTAL ACCOMODATIONS	1,542,528.00	62,235.00
			TOTAL CHARGES	8,038,766.44	93,383.65

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

Run Date: 07/15/2015
 Run Time: 00:38:43
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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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	77,015.82	ADJUSTMENTS	0.00
COVERED CHARGES	76,026.82	CONTRACTUAL ALLOW	44,211.57
NON-COVERD CHARGES	989.00	TOTAL MEDICAID LIAB	31,815.25
		LESS: COB	31,815.25
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	9		0	8,550.00		603.00
ROUTINE NURSERY	0		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	8,550.00		603.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1		0	1,391.00		0.00
NICU	6		0	6,420.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	7,811.00		0.00
TOTAL ACCOMODATIONS	16		0	16,361.00		603.00

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,282.82	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,299.25	40.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,342.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,036.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,452.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	319.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,907.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,776.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	12,531.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	333.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	376.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,426.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,332.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,126.00	0.00	INJECTABLE DRUGS	4,960.75	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	993.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,051.00	308.00			
AUDIOLOGY	123.00	38.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	59,665.82	386.00
			TOTAL ACCOMODATIONS	16,361.00	603.00
			TOTAL CHARGES	76,026.82	989.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
Run Time: 00:38:44
Page: 5

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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,962,637.36	ADJUSTMENTS	441,465.93
COVERED CHARGES	10,287,090.47	CONTRACTUAL ALLOW	8,364,835.65
NON-COVERD CHARGES	675,546.89	TOTAL MEDICAID LIAB	1,922,254.82
		LESS: COB	633.97
		LESS: COPAYMENT	4,353.00
		REIMBURSEMENT	1,917,267.85
		ALL OTHER	1,721,504.61
		FEE SCHEDULE-LAB	130,374.05
		INJECTABLE DRUGS	65,389.19

TOTAL NUMBER OF CLAIMS 4,003

Report : CLM-0804-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	147,371.37	1,621.25	OTHER LAB	68,090.00	565.00
MED/SURG SUPPLY	287,386.11	12,373.20	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	301.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	646,703.00	7,653.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,473,316.00	56,398.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	135,220.00	23,429.11	FEE SCHEDULE LAB	1,544,371.01	157,417.65
EKG/ECG	178,619.00	3,828.00	MRI SERVICES	335,795.00	10,222.00
IV THERAPY	641,151.00	42,147.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	818,972.00	120,472.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	28,086.00	456.00	REHAB THERAPY	1,197.00	0.00
RESPIRATORY SERVICES	40,866.00	2,464.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	42,250.00	1,804.00	AMBULANCE	0.00	0.00
GI SERVICES	164,327.00	3,101.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,983,410.00	1,990.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	174,900.00	2,332.00	DRUG-SPECIFIC/HOME IV	0.00	1,925.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	417,326.98	190,903.68
RADIOLOGY THERAPEUTIC	50,920.00	1,028.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	16,522.00	3,133.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,380.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	11,490.00	350.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	114,225.00	911.00
LITHOTRIPSY	40,764.00	0.00	NO CC/INVALID REV CODE	0.00	940.00
OTHER IMAGING SERVICE	250,093.00	10,739.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	28,574.00	2,405.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	185,232.00	9,694.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	103,392.00	3,063.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	74,133.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	282,388.00	501.00			
			TOTAL ANCILLARY	10,287,090.47	675,546.89
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,287,090.47	675,546.89

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015117020716	11/12/14 - 11/12/14	05/04/15	0.00	188.00	0.00	0.00	0.00
948	2015117020716	11/14/14 - 11/14/14	05/04/15	0.00	188.00	0.00	0.00	0.00
948	2015117020716	11/17/14 - 11/17/14	05/04/15	0.00	188.00	0.00	0.00	0.00
948	2015117020716	11/19/14 - 11/19/14	05/04/15	0.00	188.00	0.00	0.00	0.00
948	2015117020716	11/24/14 - 11/24/14	05/04/15	0.00	188.00	0.00	0.00	0.00
TOTAL				0.00	940.00	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	276,202.89	ADJUSTMENTS	0.00
COVERED CHARGES	212,591.39	CONTRACTUAL ALLOW	81,133.70
NON-COVERD CHARGES	63,611.50	TOTAL MEDICAID LIAB	131,457.69
		LESS: COB	131,427.69
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 102

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,918.13	293.75	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,175.65	6,245.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,013.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,575.00	12,205.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	337.00	564.00	FEE SCHEDULE LAB	44,006.00	6,814.00
EKG/ECG	4,417.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	21,034.00	1,638.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,777.00	28,803.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,079.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,880.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	237.00	3,097.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	60,842.00	893.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,996.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,698.61	403.25
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	125.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,737.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,526.00	2,655.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	205.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,150.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,262.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,601.00	0.00			
			TOTAL ANCILLARY	212,591.39	63,611.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	212,591.39	63,611.50

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	853,348.26	ADJUSTMENTS	1,762.01
COVERED CHARGES	838,581.05	CONTRACTUAL ALLOW	797,521.10
NON-COVERD CHARGES	14,767.21	TOTAL MEDICAID LIAB	41,059.95
		LESS: COB	0.00
		LESS: COPAYMENT	1,662.00
		REIMBURSEMENT	39,397.95
		TOTAL NUMBER OF CLAIMS	734

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,514.80	0.00	OTHER LAB	1,428.00	0.00
MED/SURG SUPPLY	5,976.50	277.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	49,391.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	62,547.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	161,116.00	9,162.00
EKG/ECG	7,975.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	48,922.00	474.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	776.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	448,554.00	156.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,755.75	1,041.21
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	125.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	27,500.00	3,657.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	838,581.05	14,767.21
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	838,581.05	14,767.21

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	33,690.39	ADJUSTMENTS	0.00
COVERED CHARGES	31,617.51	CONTRACTUAL ALLOW	17,558.12
NON-COVERD CHARGES	2,072.88	TOTAL MEDICAID LIAB	14,059.39
		LESS: COB	14,020.39
		LESS: COPAYMENT	39.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	18

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	491.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	394.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	356.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,252.00	772.00
EKG/ECG	638.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,909.00	158.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,132.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,930.76	305.88
RADIOLOGY THERAPEUTIC	514.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	837.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	31,617.51	2,072.88
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	31,617.51	2,072.88

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII

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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	820,617.69	ADJUSTMENTS	61,683.41
COVERED CHARGES	775,396.79	CONTRACTUAL ALLOW	663,130.59
NON-COVERD CHARGES	45,220.90	TOTAL MEDICAID LIAB	112,266.20
		LESS: COB	0.00
		LESS: COPAYMENT	126.00
		REIMBURSEMENT	112,140.20
		TOTAL NUMBER OF CLAIMS	20

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,497.57	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	111,111.00	1,326.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	210.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,424.00	14,588.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,798.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,643.04	FEE SCHEDULE LAB	19,201.00	1,304.00
EKG/ECG	3,828.00	0.00	MRI SERVICES	9,783.00	0.00
IV THERAPY	22,611.00	2,216.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	288,563.00	5.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,204.00	836.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	14,044.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,032.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	40,185.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	41,427.22	22,338.86
RADIOLOGY THERAPEUTIC	6,906.00	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	350.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	168,438.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,927.00	754.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,150.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,116.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,801.00	0.00			
			TOTAL ANCILLARY	775,396.79	45,220.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	775,396.79	45,220.90

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
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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	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF 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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,736,895.42	ADJUSTMENTS	1,240,953.66
COVERED CHARGES	6,263,967.33	CONTRACTUAL ALLOW	4,372,195.63
NON-COVERD CHARGES	472,928.09	TOTAL MEDICAID LIAB	1,891,771.70
		LESS: COB	10,050.43
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,881,721.27

TOTAL NUMBER OF ADMISSIONS 31

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	339		0	306,848.00		82,324.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	339		0	306,848.00		82,324.00
SPECIAL CARE SERVICES						
CCU	830		0	1,551,971.00		117,364.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	830		0	1,551,971.00		117,364.00
TOTAL ACCOMODATIONS	1,169		0	1,858,819.00		199,688.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

WELLSTAR WINDY HILL HOSPITAL PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
 2540 WINDY HILL RD SE 000001999A SERVICE DATES 07/01/13 THROUGH 06/30/14
 MARIETTA,GA 30067-8605 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	908,093.02	91,578.10	OTHER LAB	19,946.00	1,173.00
MED/SURG SUPPLY	194,395.31	32,967.99	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	430,891.00	35,871.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	79,079.00	829.00	OTHER THERAPEUTIC SVC	0.00	774.00
CT SCAN	55,441.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	156,060.00	6,741.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,536.00	0.00	MRI SERVICES	8,436.00	0.00
IV THERAPY	7,640.00	11,280.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	37,085.00	1,173.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,075,972.00	62,866.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	611.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	741.00	289.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	238.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	46,423.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	85,890.00	3,974.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	257,830.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,466.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,107.00	908.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,370.00	8,482.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,770.00	8,777.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,998.00	4,363.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,130.00	1,194.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,405,148.33	273,240.09
			TOTAL ACCOMODATIONS	1,858,819.00	199,688.00
			TOTAL CHARGES	6,263,967.33	472,928.09

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	474,816.19	ADJUSTMENTS	0.00
COVERED CHARGES	474,816.19	CONTRACTUAL ALLOW	324,793.93
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	150,022.26
		LESS: COB	150,022.26
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	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	102		0	169,508.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	102		0	169,508.00		0.00
TOTAL ACCOMODATIONS	102		0	169,508.00		0.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	77,280.50	0.00	OTHER LAB	3,648.00	0.00
MED/SURG SUPPLY	31,637.69	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	48,963.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,954.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,344.00	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	3,820.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,692.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	113,722.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	5,020.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	100.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	943.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,268.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	305,308.19	0.00
			TOTAL ACCOMODATIONS	169,508.00	0.00
			TOTAL CHARGES	474,816.19	0.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	916,348.47	ADJUSTMENTS	11,314.31
COVERED CHARGES	826,272.29	CONTRACTUAL ALLOW	646,955.82
NON-COVERD CHARGES	90,076.18	TOTAL MEDICAID LIAB	179,316.47
		LESS: COB	995.92
		LESS: COPAYMENT	609.00
		REIMBURSEMENT	177,711.55
		ALL OTHER	175,830.25
		FEE SCHEDULE-LAB	1,795.13
		INJECTABLE DRUGS	86.17

TOTAL NUMBER OF CLAIMS 260

Report : CLM-0804-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,527.50	12,069.00	OTHER LAB	3,519.00	0.00
MED/SURG SUPPLY	14,160.04	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	65,978.00	728.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	36,986.00	19,624.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	25,030.00	2,473.00
EKG/ECG	388.00	0.00	MRI SERVICES	78,839.00	12,699.00
IV THERAPY	2,630.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	82,576.00	34,509.00	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	54,298.00	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	31,117.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,406.75	327.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	857.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	976.00	697.18
LITHOTRIPSY	34,159.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	48,267.00	999.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,864.00	5,094.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	331,313.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	826,272.29	90,076.18
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	826,272.29	90,076.18

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	45.00	ADJUSTMENTS	0.00
COVERED CHARGES	45.00	CONTRACTUAL ALLOW	43.89
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1.11
		LESS: COB	0.00
		LESS: COPAYMENT	1.11
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
Run Time: 00:39:20
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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	81,299.56	ADJUSTMENTS	9,753.01
COVERED CHARGES	81,299.56	CONTRACTUAL ALLOW	66,330.84
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	14,968.72
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	14,962.72
		TOTAL NUMBER OF CLAIMS	2

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR WINDY HILL HOSPITAL PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
 2540 WINDY HILL RD SE 000001999A SERVICE DATES 07/01/13 THROUGH 06/30/14
 MARIETTA,GA 30067-8605 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,213.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,395.56	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	407.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	196.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	39,423.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	90.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,416.00	0.00
LITHOTRIPSY	34,159.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	81,299.56	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	81,299.56	0.00

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
Run Time: 00:39:20
Page: 13

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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF 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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,530,798.54	ADJUSTMENTS	692,317.41
COVERED CHARGES	11,400,224.55	CONTRACTUAL ALLOW	7,026,125.29
NON-COVERD CHARGES	130,573.99	TOTAL MEDICAID LIAB	4,374,099.26
		LESS: COB	22,611.89
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,351,487.37

TOTAL NUMBER OF ADMISSIONS 694

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,728		0	959,401.00		85,363.80
ROUTINE NURSERY	307		0	152,227.80		388.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,035		0	1,111,628.80		85,751.80
SPECIAL CARE SERVICES						
CCU	446		0	406,524.40		0.00
ICU	320		0	404,688.52		431.48
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	766		0	811,212.92		431.48
TOTAL ACCOMODATIONS	2,801		0	1,922,841.72		86,183.28

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,330,390.26	170.24	OTHER LAB	38,826.00	0.00
MED/SURG SUPPLY	845,197.45	4,361.47	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,464,651.10	1,301.00	EDUCATION & TRAINING	4,658.90	0.00
RADIOLOGY-DIAGNOSTIC	184,985.10	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	632,173.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	46,823.40	82.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	77,016.00	0.00	MRI SERVICES	79,510.00	0.00
IV THERAPY	191,067.47	532.00	PROFESSIONAL FEES	0.00	64.00
OPERATING ROOM	878,171.59	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	175,792.70	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	495,658.10	3,160.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	127,720.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	154,881.00	2,665.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	347,956.00	791.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	99,598.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	66,305.50	0.00	INJECTABLE DRUGS	1,287,374.58	0.00
RADIOLOGY THERAPEUTIC	477.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,492.20	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	10,614.10	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	13,593.00	3,546.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	179.00	13,539.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	357,500.08	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	53,743.30	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	82,395.00	3,631.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	60,627.00	8,688.00			
AUDIOLOGY	15,540.00	0.00			
CARDIOLOGY	180,063.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,940.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	162,463.00	1,860.00			
			TOTAL ANCILLARY	9,477,382.83	44,390.71
			TOTAL ACCOMODATIONS	1,922,841.72	86,183.28
			TOTAL CHARGES	11,400,224.55	130,573.99

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
 Run Time: 00:39:31
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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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,648.28	ADJUSTMENTS	0.00
COVERED CHARGES	25,827.28	CONTRACTUAL ALLOW	5,875.29
NON-COVERD CHARGES	821.00	TOTAL MEDICAID LIAB	19,951.99
		LESS: COB	19,951.99
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5		0	2,785.00		565.00
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	7		0	3,775.00		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	7		0	3,775.00		565.00

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,585.45	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,262.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,499.00	0.00	EDUCATION & TRAINING	59.00	0.00
RADIOLOGY-DIAGNOSTIC	440.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	836.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	404.00	0.00	PROFESSIONAL FEES	0.00	256.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,600.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	248.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,492.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	558.00	0.00	INJECTABLE DRUGS	749.83	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,549.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	111.00	0.00			
CARDIOLOGY	1,659.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	22,052.28	256.00
			TOTAL ACCOMODATIONS	3,775.00	565.00
			TOTAL CHARGES	25,827.28	821.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,581,738.62	ADJUSTMENTS	349,253.68
COVERED CHARGES	7,783,883.82	CONTRACTUAL ALLOW	5,938,675.38
NON-COVERD CHARGES	797,854.80	TOTAL MEDICAID LIAB	1,845,208.44
		LESS: COB	2,152.63
		LESS: COPAYMENT	10,407.48
		REIMBURSEMENT	1,832,648.33
		ALL OTHER	1,497,559.46
		FEE SCHEDULE-LAB	223,560.99
		INJECTABLE DRUGS	111,527.88
		TOTAL NUMBER OF CLAIMS	5,848

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	251,416.00	2,769.89	OTHER LAB	55,158.00	330.00
MED/SURG SUPPLY	285,355.20	19,166.92	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	25.00	EDUCATION & TRAINING	0.00	1,353.00
RADIOLOGY-DIAGNOSTIC	314,309.00	8,931.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,011,997.00	48,612.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	13,972.00	6,686.77	FEE SCHEDULE LAB	1,014,682.20	198,755.50
EKG/ECG	95,266.00	0.00	MRI SERVICES	265,586.00	0.00
IV THERAPY	171,084.61	42,552.82	PROFESSIONAL FEES	0.00	1,850.00
OPERATING ROOM	602,348.06	36,807.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,877.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	110,899.40	5,698.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	115,490.00	1,587.00	AMBULANCE	0.00	0.00
GI SERVICES	308,470.83	19,223.17	CAST ROOM	0.00	0.00
EMERGENCY ROOM	793,849.00	3,461.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	80,237.50	560.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	637,009.62	174,485.98
RADIOLOGY THERAPEUTIC	45,107.00	2,385.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,465.00	4,011.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,991.00	1,797.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,182.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	290,125.40	35,759.60	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,773.00	98,756.65
LITHOTRIPSY	95,588.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	225,373.00	28,246.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,377.00	4,879.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	301,931.00	35,664.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	281,604.00	9,706.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	166,490.00	0.00			
ORGAN ACQUISITION	0.00	6.00			
TREATMENT/OBSERV. RM	222,052.00	2,607.00			
			TOTAL ANCILLARY	7,783,883.82	797,854.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,783,883.82	797,854.80

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

Run Date: 07/15/2015
Run Time: 00:39:59
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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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	143,880.15	ADJUSTMENTS	0.00
COVERED CHARGES	111,999.90	CONTRACTUAL ALLOW	44,314.63
NON-COVERD CHARGES	31,880.25	TOTAL MEDICAID LIAB	67,685.27
		LESS: COB	67,571.64
		LESS: COPAYMENT	113.63
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 88

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,213.08	36.43	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,340.70	92.78	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,538.00	465.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	25,384.00	1,922.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	128.00	FEE SCHEDULE LAB	20,095.00	4,154.00
EKG/ECG	1,254.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,764.00	341.00	PROFESSIONAL FEES	0.00	128.00
OPERATING ROOM	12,802.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	942.00	285.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,572.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,761.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,680.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,192.12	18,237.04
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	1,584.00	671.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	2,700.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,725.00	519.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,554.00	1,394.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,949.00	807.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,650.00	0.00			
			TOTAL ANCILLARY	111,999.90	31,880.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	111,999.90	31,880.25

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
Run Time: 00:40:01
Page: 9

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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	252,308.94	ADJUSTMENTS	990.85
COVERED CHARGES	239,724.53	CONTRACTUAL ALLOW	219,090.44
NON-COVERD CHARGES	12,584.41	TOTAL MEDICAID LIAB	20,634.09
		LESS: COB	1.46
		LESS: COPAYMENT	732.00
		REIMBURSEMENT	19,900.63
		TOTAL NUMBER OF CLAIMS	369

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,317.68	0.00	OTHER LAB	1,145.00	0.00
MED/SURG SUPPLY	5,275.53	802.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	65.00
RADIOLOGY-DIAGNOSTIC	15,853.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,557.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	320.00	FEE SCHEDULE LAB	19,668.00	3,957.00
EKG/ECG	4,180.00	0.00	MRI SERVICES	2,638.00	0.00
IV THERAPY	9,193.00	1,101.61	PROFESSIONAL FEES	0.00	64.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,545.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	136,350.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18,277.32	4,987.80
RADIOLOGY THERAPEUTIC	477.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	407.00	167.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	183.00	82.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	107.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,311.00	1,038.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,240.00	0.00			
			TOTAL ANCILLARY	239,724.53	12,584.41
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	239,724.53	12,584.41

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
Run Time: 00:40:04
Page: 11

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 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,711.53	ADJUSTMENTS	0.00
COVERED CHARGES	4,656.60	CONTRACTUAL ALLOW	1,732.11
NON-COVERD CHARGES	54.93	TOTAL MEDICAID LIAB	2,924.49
		LESS: COB	2,921.49
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	6

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
 Run Time: 00:40:04
 Page: 12

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21.60	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	52.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	220.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	993.00	52.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,332.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	2.93
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	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,038.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,656.60	54.93
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,656.60	54.93

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 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,252.96	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	16,954.00	7.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	65.00
RADIOLOGY-DIAGNOSTIC	2,506.00	220.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	26,425.00	2,462.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	14,277.40	3,988.60
EKG/ECG	836.00	0.00	MRI SERVICES	2,865.00	0.00
IV THERAPY	25,683.00	1,322.72	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,560.00	4,406.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,106.00	248.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,474.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,011.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,534.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,035,395.25	77,665.04
RADIOLOGY THERAPEUTIC	60,392.00	477.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	16,062.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	1,344.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	30,553.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,036.00	1,394.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,193.00	2,473.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,480.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,800.00	0.00			
			TOTAL ANCILLARY	1,295,395.61	96,072.36
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,295,395.61	96,072.36

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
Run Time: 00:40:07
Page: 15

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	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF 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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,488,577.78	ADJUSTMENTS	164,366.59
COVERED CHARGES	16,173,104.84	CONTRACTUAL ALLOW	8,296,388.25
NON-COVERD CHARGES	315,472.94	TOTAL MEDICAID LIAB	7,876,716.59
		LESS: COB	17,690.74
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,859,025.85

TOTAL NUMBER OF ADMISSIONS 1,737

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	9,393		0	9,243,616.00		206,417.00
ROUTINE NURSERY	117		0	70,200.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	9,510		0	9,313,816.00		206,417.00
SPECIAL CARE SERVICES						
CCU	250		0	393,160.00		0.00
ICU	111		0	266,955.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		52	0.00		53,040.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	361		52	660,115.00		53,040.00
TOTAL ACCOMODATIONS	9,871		52	9,973,931.00		259,457.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,585,524.43	14,150.80	OTHER LAB	36,816.00	707.00
MED/SURG SUPPLY	268,436.09	3,635.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,742,374.00	8,093.00	EDUCATION & TRAINING	1,040.00	44.00
RADIOLOGY-DIAGNOSTIC	91,297.00	1,073.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	330,609.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	30,571.73	0.06	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	54,375.00	0.00	MRI SERVICES	61,205.00	0.00
IV THERAPY	96,388.00	618.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	213,476.00	12,844.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	146,315.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	243,231.00	153.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	38,220.00	1,194.00	AMBULANCE	0.00	0.00
GI SERVICES	25,062.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	496,028.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	544.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	17,403.00	0.00	INJECTABLE DRUGS	226,345.60	4,963.08
RADIOLOGY THERAPEUTIC	18,055.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	429.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,502.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	14,997.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,669.00	53.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	11,978.99	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	32,835.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	66,813.00	3,676.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	60,523.00	1,967.00			
AUDIOLOGY	4,335.00	0.00			
CARDIOLOGY	192,112.00	1,653.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,809.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	77,855.00	1,192.00			
			TOTAL ANCILLARY	6,199,173.84	56,015.94
			TOTAL ACCOMODATIONS	9,973,931.00	259,457.00
			TOTAL CHARGES	16,173,104.84	315,472.94

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	188,107.07	ADJUSTMENTS	0.00
COVERED CHARGES	27,030.98	CONTRACTUAL ALLOW	3,321.83
NON-COVERD CHARGES	161,076.09	TOTAL MEDICAID LIAB	23,709.15
		LESS: COB	23,709.15
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 9

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	17		0	10,887.00		6,321.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	17		0	10,887.00		6,321.00
SPECIAL CARE SERVICES						
CCU	12		0	0.00		18,732.00
ICU	4		0	0.00		9,620.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	0.00		28,352.00
TOTAL ACCOMODATIONS	33		0	10,887.00		34,673.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,834.42	22,964.96	OTHER LAB	0.00	1,118.00
MED/SURG SUPPLY	2,018.56	9,503.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,214.00	33,468.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	2,962.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	7,861.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,796.13	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	241.00	2,651.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	3,369.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,327.00	3,770.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	21,244.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,194.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	8,345.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	315.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	53.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	2,313.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	1,679.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	3,306.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	16,143.98	126,403.09
			TOTAL ACCOMODATIONS	10,887.00	34,673.00
			TOTAL CHARGES	27,030.98	161,076.09

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
Run Time: 00:40:23
Page: 5

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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,030,498.61	ADJUSTMENTS	368,239.44
COVERED CHARGES	10,551,309.05	CONTRACTUAL ALLOW	7,408,095.12
NON-COVERD CHARGES	479,189.56	TOTAL MEDICAID LIAB	3,143,213.93
		LESS: COB	8,571.80
		LESS: COPAYMENT	6,909.00
		REIMBURSEMENT	3,127,733.13
		ALL OTHER	2,442,443.92
		FEE SCHEDULE-LAB	93,218.90
		INJECTABLE DRUGS	592,070.31

TOTAL NUMBER OF CLAIMS 3,885

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	304,895.47	4,047.03	OTHER LAB	65,194.00	0.00
MED/SURG SUPPLY	212,551.81	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	65.00	485.00
RADIOLOGY-DIAGNOSTIC	403,284.00	4,620.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,175,486.00	73,597.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	3,687.00	FEE SCHEDULE LAB	1,164,772.00	160,950.80
EKG/ECG	108,790.00	4,338.00	MRI SERVICES	267,519.00	9,708.00
IV THERAPY	429,326.00	26,022.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	509,392.50	78,337.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	10,437.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	50,305.00	2,317.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	152,964.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	222,966.00	9,596.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,526,151.00	3,301.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,400.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	2,082.08
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	952,801.15	18,337.15
RADIOLOGY THERAPEUTIC	475.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	382.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	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	5,927.00	2,679.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	2,215,510.00	22,990.00	IMPL DEV CHARGE PATIENTS	16,022.12	395.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	12,775.00
OTHER IMAGING SERVICE	241,867.00	21,548.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,349.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	141,034.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	137,187.00	6,918.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	78,332.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	142,306.00	417.00			
			TOTAL ANCILLARY	10,551,309.05	479,189.56
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,551,309.05	479,189.56

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014070050599	02/07/14 - 02/07/14	03/17/14	0.00	365.00	0.00	0.00	0.00
905	2014073009675	12/02/13 - 12/02/13	03/17/14	0.00	365.00	0.00	0.00	0.00
905	2014073009675	12/03/13 - 12/03/13	03/17/14	0.00	365.00	0.00	0.00	0.00
905	2014073009675	12/04/13 - 12/04/13	03/17/14	0.00	365.00	0.00	0.00	0.00
905	2014073009675	12/05/13 - 12/05/13	03/17/14	0.00	365.00	0.00	0.00	0.00
905	2014073009675	12/06/13 - 12/06/13	03/17/14	0.00	365.00	0.00	0.00	0.00
905	2014073009675	12/09/13 - 12/09/13	03/17/14	0.00	365.00	0.00	0.00	0.00
905	2014073009675	12/10/13 - 12/10/13	03/17/14	0.00	365.00	0.00	0.00	0.00
905	2014073009675	12/11/13 - 12/11/13	03/17/14	0.00	365.00	0.00	0.00	0.00
905	2014073009675	12/12/13 - 12/12/13	03/17/14	0.00	365.00	0.00	0.00	0.00
905	2014073009675	12/13/13 - 12/13/13	03/17/14	0.00	365.00	0.00	0.00	0.00
905	2014073009675	12/16/13 - 12/16/13	03/17/14	0.00	365.00	0.00	0.00	0.00
905	2014073009675	12/17/13 - 12/17/13	03/17/14	0.00	365.00	0.00	0.00	0.00
905	2014080071778	03/07/14 - 03/07/14	03/24/14	0.00	365.00	0.00	0.00	0.00
905	2014080071778	03/10/14 - 03/10/14	03/24/14	0.00	365.00	0.00	0.00	0.00
905	2014080071778	03/11/14 - 03/11/14	03/24/14	0.00	365.00	0.00	0.00	0.00
905	2014087061315	03/10/14 - 03/10/14	03/31/14	0.00	365.00	0.00	0.00	0.00
905	2014098047080	03/10/14 - 03/10/14	04/14/14	0.00	365.00	0.00	0.00	0.00
905	2014129079940	03/27/14 - 03/27/14	05/12/14	0.00	365.00	0.00	0.00	0.00
905	2014129079940	03/28/14 - 03/28/14	05/12/14	0.00	365.00	0.00	0.00	0.00
905	2014129079940	03/31/14 - 03/31/14	05/12/14	0.00	365.00	0.00	0.00	0.00
905	2014129079940	04/02/14 - 04/02/14	05/12/14	0.00	365.00	0.00	0.00	0.00
905	2014129079940	04/04/14 - 04/04/14	05/12/14	0.00	365.00	0.00	0.00	0.00
905	2014129079940	04/07/14 - 04/07/14	05/12/14	0.00	365.00	0.00	0.00	0.00
905	2014129079940	04/09/14 - 04/09/14	05/12/14	0.00	365.00	0.00	0.00	0.00
905	2014129079940	04/18/14 - 04/18/14	05/12/14	0.00	365.00	0.00	0.00	0.00
905	2014129079940	04/21/14 - 04/21/14	05/12/14	0.00	365.00	0.00	0.00	0.00
905	2014129079940	04/23/14 - 04/23/14	05/12/14	0.00	365.00	0.00	0.00	0.00
905	2014129079940	04/30/14 - 04/30/14	05/12/14	0.00	365.00	0.00	0.00	0.00
905	2014129079940	05/01/14 - 05/01/14	05/12/14	0.00	365.00	0.00	0.00	0.00
905	2014129079940	05/02/14 - 05/02/14	05/12/14	0.00	365.00	0.00	0.00	0.00
905	2014142069221	04/21/14 - 04/21/14	05/26/14	0.00	365.00	0.00	0.00	0.00
905	2014142069221	05/01/14 - 05/01/14	05/26/14	0.00	365.00	0.00	0.00	0.00
905	2014142069221	05/02/14 - 05/02/14	05/26/14	0.00	365.00	0.00	0.00	0.00
905	2014239056065	06/20/14 - 06/20/14	09/01/14	0.00	365.00	0.00	0.00	0.00
TOTAL				0.00	12,775.00	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	78,416.15	ADJUSTMENTS	0.00
COVERED CHARGES	39,255.92	CONTRACTUAL ALLOW	3,422.60
NON-COVERD CHARGES	39,160.23	TOTAL MEDICAID LIAB	35,833.32
		LESS: COB	35,821.32
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 24

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,380.92	93.73	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	384.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,692.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,329.00	8,202.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,395.00	1,671.00
EKG/ECG	482.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,790.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	108.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	272.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,074.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	140.00	24,685.50
RADIOLOGY THERAPEUTIC	867.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	8,470.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,190.00
OTHER IMAGING SERVICE	1,632.00	730.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,595.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	791.00	1,316.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	126.00	0.00			
			TOTAL ANCILLARY	39,255.92	39,160.23
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	39,255.92	39,160.23

Report : CLM-0806-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013361001884	11/15/13 - 11/15/13	12/30/13	0.00	365.00	0.00	5,088.00	0.00
905	2013361001884	11/14/13 - 11/14/13	12/30/13	0.00	365.00	0.00	5,088.00	0.00
905	2013361001884	11/11/13 - 11/11/13	12/30/13	0.00	365.00	0.00	5,088.00	0.00
905	2013361001884	11/08/13 - 11/08/13	12/30/13	0.00	365.00	0.00	5,088.00	0.00
905	2013361001884	11/07/13 - 11/07/13	12/30/13	0.00	365.00	0.00	5,088.00	0.00
905	2013361001884	11/06/13 - 11/06/13	12/30/13	0.00	365.00	0.00	5,088.00	0.00
TOTAL				0.00	2,190.00	0.00	30,528.00	0.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	470,328.55	ADJUSTMENTS	432.52
COVERED CHARGES	454,916.55	CONTRACTUAL ALLOW	428,848.52
NON-COVERD CHARGES	15,412.00	TOTAL MEDICAID LIAB	26,068.03
		LESS: COB	35.26
		LESS: COPAYMENT	831.00
		REIMBURSEMENT	25,201.77
		TOTAL NUMBER OF CLAIMS	466

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,158.29	0.00	OTHER LAB	1,825.00	0.00
MED/SURG SUPPLY	4,781.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	31,715.00	176.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	43,405.00	6,152.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	92,929.00	8,096.00
EKG/ECG	5,784.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	20,687.00	310.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,709.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,927.00	139.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	231,871.00	539.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,325.26	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	4,130.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	670.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	454,916.55	15,412.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	454,916.55	15,412.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,184.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,184.00	CONTRACTUAL ALLOW	579.77
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	604.23
		LESS: COB	601.23
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 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	286.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	898.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,184.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,184.00	0.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	578,950.06	ADJUSTMENTS	27,744.20
COVERED CHARGES	542,591.00	CONTRACTUAL ALLOW	401,487.90
NON-COVERD CHARGES	36,359.06	TOTAL MEDICAID LIAB	141,103.10
		LESS: COB	0.00
		LESS: COPAYMENT	249.00
		REIMBURSEMENT	140,854.10
		TOTAL NUMBER OF CLAIMS	25

Report : CLM-0812-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,013.88	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	38,723.00	2,773.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	732.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,835.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	403.00	763.00	FEE SCHEDULE LAB	22,279.00	2,679.00
EKG/ECG	1,124.00	241.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,561.00	420.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	97,286.68	13,654.32	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	438.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,950.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,276.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	550.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	3,717.99
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	53,728.64	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	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	236.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	203,280.00	0.00	IMPL DEV CHARGE PATIENTS	30,362.80	2,450.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,735.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,785.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	21,562.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	15,730.00	0.00			
			TOTAL ANCILLARY	542,591.00	36,359.06
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	542,591.00	36,359.06

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

NORTH GEORGIA MEDICAL CENTER
 1362 S MAIN ST
 ELLIJAY, GA 30540-5410

PROVIDER NUMBER
 000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,223,497.48	ADJUSTMENTS	47,024.41
COVERED CHARGES	1,213,046.97	CONTRACTUAL ALLOW	691,673.13
NON-COVERD CHARGES	10,450.51	TOTAL MEDICAID LIAB	521,373.84
		LESS: COB	4,258.32
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	517,115.52

TOTAL NUMBER OF ADMISSIONS 73

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	161		0	41,849.60		8,777.25
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	161		0	41,849.60		8,777.25
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	87		0	90,040.80		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	87		0	90,040.80		0.00
TOTAL ACCOMODATIONS	248		0	131,890.40		8,777.25

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

NORTH GEORGIA MEDICAL CENTER
 1362 S MAIN ST
 ELLIJAY, GA 30540-5410

PROVIDER NUMBER
 000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	291,921.98	0.00	OTHER LAB	1,549.95	0.00
MED/SURG SUPPLY	102,273.43	92.61	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	159,565.14	0.00	EDUCATION & TRAINING	437.50	0.00
RADIOLOGY-DIAGNOSTIC	29,774.90	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	40,018.42	1,466.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,482.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	26,539.75	0.00	MRI SERVICES	2,011.50	0.00
IV THERAPY	33,774.35	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	78,381.95	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	55,665.55	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	53,280.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	62,540.98	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	23,347.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,176.58	0.00	INJECTABLE DRUGS	6,843.04	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	729.25	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	726.25	114.15	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	48,127.52	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	15,952.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	13,803.25	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	29,233.03	0.00			
			TOTAL ANCILLARY	1,081,156.57	1,673.26
			TOTAL ACCOMODATIONS	131,890.40	8,777.25
			TOTAL CHARGES	1,213,046.97	10,450.51

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NORTH GEORGIA MEDICAL CENTER
1362 S MAIN ST
ELLIJAY,GA 30540-5410

PROVIDER NUMBER
000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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NORTH GEORGIA MEDICAL CENTER
1362 S MAIN ST
ELLIJAY,GA 30540-5410

PROVIDER NUMBER
000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,145,322.68	ADJUSTMENTS	43,144.80
COVERED CHARGES	2,074,817.07	CONTRACTUAL ALLOW	1,618,971.06
NON-COVERD CHARGES	70,505.61	TOTAL MEDICAID LIAB	455,846.01
		LESS: COB	1,237.27
		LESS: COPAYMENT	1,800.00
		REIMBURSEMENT	452,808.74
		ALL OTHER	405,961.55
		FEE SCHEDULE-LAB	46,038.22
		INJECTABLE DRUGS	808.97
		TOTAL NUMBER OF CLAIMS	1,625

Report : CLM-0804-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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NORTH GEORGIA MEDICAL CENTER
 1362 S MAIN ST
 ELLIJAY, GA 30540-5410

PROVIDER NUMBER
 000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	117,656.44	0.00	OTHER LAB	15,560.75	0.00
MED/SURG SUPPLY	123,741.19	174.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	129.00
RADIOLOGY-DIAGNOSTIC	127,074.10	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	89,650.58	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,025.00	0.00	FEE SCHEDULE LAB	335,432.50	49,196.71
EKG/ECG	52,544.60	3,229.75	MRI SERVICES	23,911.02	905.75
IV THERAPY	88,599.25	10,601.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	242,585.10	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	14,961.75	1,880.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	106,480.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	439,985.80	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	101,122.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,736.10	920.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	47,438.64	210.60	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	1,898.70
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,416.20	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	37,767.15	310.80			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	36,460.80	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	16,265.80	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	27,401.55	1,048.80			
			TOTAL ANCILLARY	2,074,817.07	70,505.61
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,074,817.07	70,505.61

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

Run Date: 07/15/2015
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTH GEORGIA MEDICAL CENTER
1362 S MAIN ST
ELLIJAY,GA 30540-5410

PROVIDER NUMBER
000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,025.48	ADJUSTMENTS	0.00
COVERED CHARGES	10,282.48	CONTRACTUAL ALLOW	5,395.11
NON-COVERD CHARGES	743.00	TOTAL MEDICAID LIAB	4,887.37
		LESS: COB	4,884.37
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 11

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTH GEORGIA MEDICAL CENTER
 1362 S MAIN ST
 ELLIJAY, GA 30540-5410

PROVIDER NUMBER
 000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	94.76	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	100.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	230.45	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,557.71	538.25
EKG/ECG	191.00	204.75	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	143.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,178.25	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	50.76	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,735.75	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	10,282.48	743.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,282.48	743.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
Run Time: 00:41:02
Page: 8

NORTH GEORGIA MEDICAL CENTER
1362 S MAIN ST
ELLIJAY,GA 30540-5410

PROVIDER NUMBER
000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	146,879.52	ADJUSTMENTS	161.82
COVERED CHARGES	145,552.52	CONTRACTUAL ALLOW	134,867.98
NON-COVERD CHARGES	1,327.00	TOTAL MEDICAID LIAB	10,684.54
		LESS: COB	0.00
		LESS: COPAYMENT	330.00
		REIMBURSEMENT	10,354.54
		TOTAL NUMBER OF CLAIMS	191

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

NORTH GEORGIA MEDICAL CENTER
 1362 S MAIN ST
 ELLIJAY, GA 30540-5410

PROVIDER NUMBER
 000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,742.85	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,781.45	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,850.20	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,592.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	21,331.17	1,327.00
EKG/ECG	1,182.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,720.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	598.50	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	102,808.75	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	457.85	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	486.75	0.00			
			TOTAL ANCILLARY	145,552.52	1,327.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	145,552.52	1,327.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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Page: 10

NORTH GEORGIA MEDICAL CENTER
1362 S MAIN ST
ELLIJAY,GA 30540-5410

PROVIDER NUMBER
000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,149.09	ADJUSTMENTS	0.00
COVERED CHARGES	2,126.09	CONTRACTUAL ALLOW	1,656.34
NON-COVERD CHARGES	23.00	TOTAL MEDICAID LIAB	469.75
		LESS: COB	469.75
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTH GEORGIA MEDICAL CENTER
 1362 S MAIN ST
 ELLIJAY, GA 30540-5410

PROVIDER NUMBER
 000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 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	242.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	884.59	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	997.50	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	2.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,126.09	23.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,126.09	23.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII

Run Date: 07/15/2015
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTH GEORGIA MEDICAL CENTER
1362 S MAIN ST
ELLIJAY,GA 30540-5410

PROVIDER NUMBER
000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	198,018.70	ADJUSTMENTS	5,040.66
COVERED CHARGES	193,716.09	CONTRACTUAL ALLOW	157,241.49
NON-COVERD CHARGES	4,302.61	TOTAL MEDICAID LIAB	36,474.60
		LESS: COB	0.00
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	36,450.60

TOTAL NUMBER OF CLAIMS 7

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTH GEORGIA MEDICAL CENTER
 1362 S MAIN ST
 ELLIJAY, GA 30540-5410

PROVIDER NUMBER
 000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,234.31	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	54,974.40	92.61	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	220.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	148.00
EKG/ECG	191.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	336.00	504.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	64,123.39	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	241.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	42,702.00	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	18,637.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	451.59	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	4,004.40	3,558.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	600.00	0.00			
			TOTAL ANCILLARY	193,716.09	4,302.61
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	193,716.09	4,302.61

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
Run Time: 00:41:04
Page: 14

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTH GEORGIA MEDICAL CENTER
1362 S MAIN ST
ELLIJAY,GA 30540-5410

PROVIDER NUMBER
000002043A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF 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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,202,584.39	ADJUSTMENTS	61,442.73
COVERED CHARGES	4,158,478.39	CONTRACTUAL ALLOW	2,596,341.46
NON-COVERD CHARGES	44,106.00	TOTAL MEDICAID LIAB	1,562,136.93
		LESS: COB	17,547.61
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,544,589.32

TOTAL NUMBER OF ADMISSIONS 272

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	910		0	435,840.00		31,246.00
ROUTINE NURSERY	80		0	24,320.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	990		0	460,160.00		31,246.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	202		0	242,056.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	202		0	242,056.00		0.00
TOTAL ACCOMODATIONS	1,192		0	702,216.00		31,246.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,132,593.00	0.00	OTHER LAB	16,578.00	0.00
MED/SURG SUPPLY	568,187.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	618,553.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	82,599.00	0.00	OTHER THERAPEUTIC SVC	0.00	6.00
CT SCAN	196,275.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	22,830.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	26,044.00	0.00	MRI SERVICES	59,462.00	0.00
IV THERAPY	75,989.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	166,979.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	35,187.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	93,781.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	25,280.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	87,843.00	1,110.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	17,424.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,656.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,230.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,428.00	3.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	3,312.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	10,344.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,713.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	21,846.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	12,377.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	18,430.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	68,941.00	0.00			
AMBULATORY SURGERY	3,490.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	82,234.89	1,397.00			
			TOTAL ANCILLARY	3,456,262.39	12,860.00
			TOTAL ACCOMODATIONS	702,216.00	31,246.00
			TOTAL CHARGES	4,158,478.39	44,106.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	30,337.00	ADJUSTMENTS	0.00
COVERED CHARGES	30,197.00	CONTRACTUAL ALLOW	5,995.81
NON-COVERD CHARGES	140.00	TOTAL MEDICAID LIAB	24,201.19
		LESS: COB	24,201.19
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	4		0	1,920.00		140.00
ROUTINE NURSERY	2		0	608.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	6		0	2,528.00		140.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	2,528.00		140.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,180.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,565.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,450.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	2,646.00	0.00
IV THERAPY	351.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,337.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	760.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	375.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	462.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	170.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	488.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	885.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	27,669.00	0.00
			TOTAL ACCOMODATIONS	2,528.00	140.00
			TOTAL CHARGES	30,197.00	140.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,025,698.88	ADJUSTMENTS	489,079.32
COVERED CHARGES	4,615,225.08	CONTRACTUAL ALLOW	3,569,192.46
NON-COVERD CHARGES	410,473.80	TOTAL MEDICAID LIAB	1,046,032.62
		LESS: COB	2,405.94
		LESS: COPAYMENT	2,541.00
		REIMBURSEMENT	1,041,085.68
		ALL OTHER	946,192.74
		FEE SCHEDULE-LAB	85,367.33
		INJECTABLE DRUGS	9,525.61

TOTAL NUMBER OF CLAIMS 2,939

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	408,625.05	579.00	OTHER LAB	22,880.00	0.00
MED/SURG SUPPLY	609,415.00	1,801.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	176,512.00	5,000.00	OTHER THERAPEUTIC SVC	0.00	78.00
CT SCAN	619,194.00	82,324.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,132.00	7,617.00	FEE SCHEDULE LAB	683,274.20	169,618.80
EKG/ECG	44,892.00	4,311.00	MRI SERVICES	122,954.00	8,393.00
IV THERAPY	169,580.00	30,803.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	347,778.00	24,620.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	11,765.00	1,020.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	18,479.00	506.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	58,033.00	240.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	612,528.00	4,257.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	42,441.00	330.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	124,697.00	39,514.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	877.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	559.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	34,645.00	128.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	4,583.00
LITHOTRIPSY	209,859.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	112,080.00	16,533.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,388.00	1,156.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	40,854.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	52,836.00	638.00			
AMBULATORY SURGERY	1,118.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	84,265.83	4,988.00			
			TOTAL ANCILLARY	4,615,225.08	410,473.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,615,225.08	410,473.80

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	90,054.05	ADJUSTMENTS	0.00
COVERED CHARGES	82,416.05	CONTRACTUAL ALLOW	38,107.77
NON-COVERD CHARGES	7,638.00	TOTAL MEDICAID LIAB	44,308.28
		LESS: COB	44,257.28
		LESS: COPAYMENT	51.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 59

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,173.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	13,228.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,177.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,718.00	2,549.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,857.00	2,129.00
EKG/ECG	144.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,920.00	1,097.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,416.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,121.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	45.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,152.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,753.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,122.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,652.00	314.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,400.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	75.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,025.00	1,474.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,659.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,854.05	0.00			
			TOTAL ANCILLARY	82,416.05	7,638.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	82,416.05	7,638.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	337,795.62	ADJUSTMENTS	1,459.38
COVERED CHARGES	319,115.62	CONTRACTUAL ALLOW	288,908.02
NON-COVERD CHARGES	18,680.00	TOTAL MEDICAID LIAB	30,207.60
		LESS: COB	0.00
		LESS: COPAYMENT	957.01
		REIMBURSEMENT	29,250.59
		TOTAL NUMBER OF CLAIMS	540

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,875.25	0.00	OTHER LAB	2,778.00	0.00
MED/SURG SUPPLY	9,582.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,946.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	25,540.00	3,404.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	62,840.00	7,690.00
EKG/ECG	3,024.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,765.00	1,404.00	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	438.00	56.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	153,822.00	548.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,199.25	471.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,199.00	5,107.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,107.12	0.00			
			TOTAL ANCILLARY	319,115.62	18,680.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	319,115.62	18,680.00

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	358.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	184.00	0.00	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	1,717.00	158.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	265.00	62.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,721.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	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	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	5,649.00	220.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,649.00	220.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	142,105.00	ADJUSTMENTS	16,008.93
COVERED CHARGES	141,164.00	CONTRACTUAL ALLOW	109,890.65
NON-COVERD CHARGES	941.00	TOTAL MEDICAID LIAB	31,273.35
		LESS: COB	0.00
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	31,243.35
		TOTAL NUMBER OF CLAIMS	6

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,780.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	31,280.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	257.00	380.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,602.00	222.00
EKG/ECG	288.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,366.00	189.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,366.00	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	3,520.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	274.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,233.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	489.00	22.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,296.00	128.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	57,081.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	152.00	0.00			
			TOTAL ANCILLARY	141,164.00	941.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	141,164.00	941.00

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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SUMMARY TYPE VIII

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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

WEST GEORGIA MEDICAL CENTER, INC.
 1514 VERNON RD
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER 000002065A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,829,373.38	ADJUSTMENTS	730,610.99
COVERED CHARGES	14,800,094.22	CONTRACTUAL ALLOW	9,706,303.73
NON-COVERD CHARGES	29,279.16	TOTAL MEDICAID LIAB	5,093,790.49
		LESS: COB	51,784.96
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,042,005.53

TOTAL NUMBER OF ADMISSIONS 667

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,164		0	1,006,860.00		17,460.00
ROUTINE NURSERY	156		0	87,925.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,320		0	1,094,785.00		17,460.00
SPECIAL CARE SERVICES						
CCU	1,006		0	1,541,410.00		0.00
ICU	362		0	707,710.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,368		0	2,249,120.00		0.00
TOTAL ACCOMODATIONS	2,688		0	3,343,905.00		17,460.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

WEST GEORGIA MEDICAL CENTER, INC.
 1514 VERNON RD
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,702,908.45	0.00	OTHER LAB	62,506.00	0.00
MED/SURG SUPPLY	688,642.51	0.00	RECREATIONAL THERAPY	1,145.30	0.00
LABORATORY-GENERAL	2,055,991.01	0.00	EDUCATION & TRAINING	2,175.60	0.00
RADIOLOGY-DIAGNOSTIC	264,415.85	0.00	OTHER THERAPEUTIC SVC	887.25	1,553.10
CT SCAN	726,749.75	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	121,494.35	0.11	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	115,366.50	0.00	MRI SERVICES	95,212.40	0.00
IV THERAPY	15,383.20	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,734,768.80	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	190,177.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	594,089.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	339,058.10	0.00	AMBULANCE	0.00	0.00
GI SERVICES	125,055.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	812,964.55	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	118,360.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	54,352.90	0.00	INJECTABLE DRUGS	35.00	0.00
RADIOLOGY THERAPEUTIC	31,974.30	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,414.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	95,506.80	1,487.30	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	1,235.40	172.85	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	124.85	2,268.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	256,433.60	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	82,239.60	5,323.55			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	186,797.60	1,013.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	98,302.20	0.00			
AUDIOLOGY	11,240.10	0.00			
CARDIOLOGY	832,764.95	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	21,325.20	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,091.60	0.00			
			TOTAL ANCILLARY	11,456,189.22	11,819.16
			TOTAL ACCOMODATIONS	3,343,905.00	17,460.00
			TOTAL CHARGES	14,800,094.22	29,279.16

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

WEST GEORGIA MEDICAL CENTER, INC.
 1514 VERNON RD
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	268,935.30	ADJUSTMENTS	0.00
COVERED CHARGES	267,817.75	CONTRACTUAL ALLOW	99,197.04
NON-COVERD CHARGES	1,117.55	TOTAL MEDICAID LIAB	168,620.71
		LESS: COB	168,620.71
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 15

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	22		0	19,030.00		330.00
ROUTINE NURSERY	8		0	3,840.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	30		0	22,870.00		330.00
SPECIAL CARE SERVICES						
CCU	5		0	7,625.00		0.00
ICU	14		0	27,370.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	19		0	34,995.00		0.00
TOTAL ACCOMODATIONS	49		0	57,865.00		330.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

WEST GEORGIA MEDICAL CENTER, INC.
 1514 VERNON RD
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,270.68	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,490.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	35,152.35	0.00	EDUCATION & TRAINING	58.80	0.00
RADIOLOGY-DIAGNOSTIC	4,356.55	0.00	OTHER THERAPEUTIC SVC	0.00	281.05
CT SCAN	4,224.15	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,045.25	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	697.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	32,039.15	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	26,587.90	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	24,964.20	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,921.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,684.90	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,928.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,616.45	0.00	INJECTABLE DRUGS	16,534.12	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,837.80	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	988.45	506.50			
AUDIOLOGY	416.30	0.00			
CARDIOLOGY	3,138.10	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	209,952.75	787.55
			TOTAL ACCOMODATIONS	57,865.00	330.00
			TOTAL CHARGES	267,817.75	1,117.55

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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WEST GEORGIA MEDICAL CENTER, INC.
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,105,021.30	ADJUSTMENTS	644,784.20
COVERED CHARGES	13,896,667.06	CONTRACTUAL ALLOW	11,018,318.90
NON-COVERD CHARGES	1,208,354.24	TOTAL MEDICAID LIAB	2,878,348.16
		LESS: COB	17,958.62
		LESS: COPAYMENT	6,885.96
		REIMBURSEMENT	2,853,503.58
		ALL OTHER	2,379,195.39
		FEE SCHEDULE-LAB	291,339.76
		INJECTABLE DRUGS	182,968.43

TOTAL NUMBER OF CLAIMS 7,284

WEST GEORGIA MEDICAL CENTER, INC.
 1514 VERNON RD
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	345,145.73	2,169.00	OTHER LAB	245,771.35	0.00
MED/SURG SUPPLY	364,796.87	166,741.55	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	283.10	EDUCATION & TRAINING	0.00	529.20
RADIOLOGY-DIAGNOSTIC	482,860.00	2,738.90	OTHER THERAPEUTIC SVC	1,028.70	657.20
CT SCAN	1,141,511.45	111,422.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	46,252.05	7,351.19	FEE SCHEDULE LAB	2,247,641.27	362,356.15
EKG/ECG	133,058.40	5,161.50	MRI SERVICES	87,892.35	2,367.30
IV THERAPY	354,037.60	25,077.70	PROFESSIONAL FEES	0.00	164.30
OPERATING ROOM	1,664,693.52	217,679.02	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	44,402.30	426.05	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	215,934.05	4,980.95	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	548,192.55	0.00	AMBULANCE	0.00	0.00
GI SERVICES	248,025.75	6,848.25	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,303,534.55	55,147.45	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	234,003.55	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	502,066.52	166,427.23
RADIOLOGY THERAPEUTIC	271,827.90	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,664.30	749.75	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,146.90	1,189.65	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	743.65	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	38,577.55	582.05	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	62.50
OTHER IMAGING SERVICE	392,777.30	32,946.15			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	37,018.50	2,027.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	95,242.90	4,013.70			
AUDIOLOGY	549.30	192.75			
CARDIOLOGY	444,334.50	25,108.15			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	6,219.85	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	389,459.50	2,210.05			
			TOTAL ANCILLARY	13,896,667.06	1,208,354.24
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,896,667.06	1,208,354.24

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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WEST GEORGIA MEDICAL CENTER, INC.
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
8100	5914196001552	06/10/14 - 06/11/14	07/21/14	0.00	62.50	0.00	0.00	0.00
TOTAL				0.00	62.50	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WEST GEORGIA MEDICAL CENTER, INC.
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	459,458.28	ADJUSTMENTS	0.00
COVERED CHARGES	390,607.70	CONTRACTUAL ALLOW	133,445.32
NON-COVERD CHARGES	68,850.58	TOTAL MEDICAID LIAB	257,162.38
		LESS: COB	257,010.02
		LESS: COPAYMENT	152.36
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 217

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WEST GEORGIA MEDICAL CENTER, INC.
 1514 VERNON RD
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,796.01	0.00	OTHER LAB	684.60	0.00
MED/SURG SUPPLY	9,496.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,916.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,834.15	21,351.55	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	67,042.65	7,450.70
EKG/ECG	2,996.00	139.50	MRI SERVICES	0.00	0.00
IV THERAPY	11,153.20	596.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	58,653.00	22,156.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,335.45	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	600.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	24,932.95	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	100,193.35	715.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,007.80	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,585.24	609.70
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	595.60	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	518.55	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	719.60	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	216.60	1,279.70
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,164.50	11,769.08			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,521.40	99.40			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,418.80	1,569.05			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	29,339.90	0.00			
			TOTAL ANCILLARY	390,607.70	68,850.58
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	390,607.70	68,850.58

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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WEST GEORGIA MEDICAL CENTER, INC.
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	856,619.50	ADJUSTMENTS	1,120.74
COVERED CHARGES	829,926.34	CONTRACTUAL ALLOW	776,930.14
NON-COVERD CHARGES	26,693.16	TOTAL MEDICAID LIAB	52,996.20
		LESS: COB	240.90
		LESS: COPAYMENT	1,722.00
		REIMBURSEMENT	51,033.30
		TOTAL NUMBER OF CLAIMS	944

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

WEST GEORGIA MEDICAL CENTER, INC.
 1514 VERNON RD
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,295.94	0.00	OTHER LAB	1,032.30	0.00
MED/SURG SUPPLY	7,331.15	1,961.15	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	36,174.05	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	28,059.10	2,390.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	142,507.45	16,099.65
EKG/ECG	5,719.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	114.60	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,311.80	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,302.40	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,191.95	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,335.05	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,573.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	559,357.20	4,143.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	684.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,787.45	275.71
RADIOLOGY THERAPEUTIC	823.95	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,450.05	1,823.65			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	874.65	0.00			
			TOTAL ANCILLARY	829,926.34	26,693.16
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	829,926.34	26,693.16

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WEST GEORGIA MEDICAL CENTER, INC.
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,404.05	ADJUSTMENTS	0.00
COVERED CHARGES	21,746.65	CONTRACTUAL ALLOW	10,375.04
NON-COVERD CHARGES	657.40	TOTAL MEDICAID LIAB	11,371.61
		LESS: COB	11,362.61
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	26

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WEST GEORGIA MEDICAL CENTER, INC.
 1514 VERNON RD
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	160.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	117.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	482.95	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,272.40	220.30
EKG/ECG	139.50	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	426.05	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,086.30	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	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	437.10			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	21,746.65	657.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	21,746.65	657.40

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII

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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WEST GEORGIA MEDICAL CENTER, INC.
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,100,491.86	ADJUSTMENTS	228,270.75
COVERED CHARGES	1,934,432.49	CONTRACTUAL ALLOW	1,480,236.51
NON-COVERD CHARGES	166,059.37	TOTAL MEDICAID LIAB	454,195.98
		LESS: COB	0.00
		LESS: COPAYMENT	861.00
		REIMBURSEMENT	453,334.98
		TOTAL NUMBER OF CLAIMS	86

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WEST GEORGIA MEDICAL CENTER, INC.
 1514 VERNON RD
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,617.98	168.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	76,790.55	91,366.45	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	58.80
RADIOLOGY-DIAGNOSTIC	14,973.95	8,904.10	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,400.05	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	480.95	1,230.52	FEE SCHEDULE LAB	45,647.80	8,612.22
EKG/ECG	2,371.50	837.00	MRI SERVICES	2,367.30	0.00
IV THERAPY	166,836.05	1,958.40	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	316,871.87	14,084.33	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,812.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	24,734.55	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,087.15	775.20	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,919.65	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	878,094.54	11,084.60
RADIOLOGY THERAPEUTIC	185,431.90	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	576.80	376.80	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	382.30	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	12,314.20	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	38,689.50	550.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,991.80	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,196.15	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	83,695.90	26,051.95			
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	10,147.30	0.00			
			TOTAL ANCILLARY	1,934,432.49	166,059.37
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,934,432.49	166,059.37

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WEST GEORGIA MEDICAL CENTER, INC.
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,776.55	ADJUSTMENTS	0.00
COVERED CHARGES	19,128.60	CONTRACTUAL ALLOW	7,440.35
NON-COVERD CHARGES	647.95	TOTAL MEDICAID LIAB	11,688.25
		LESS: COB	11,679.25
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0814-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WEST GEORGIA MEDICAL CENTER, INC.
 1514 VERNON RD
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	258.74	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	221.45	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	1,073.60	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,951.05	119.25	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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	13,055.56	528.70
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	568.20	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	19,128.60	647.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	19,128.60	647.95

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	253,046.00	ADJUSTMENTS	0.00
COVERED CHARGES	252,086.00	CONTRACTUAL ALLOW	97,665.04
NON-COVERD CHARGES	960.00	TOTAL MEDICAID LIAB	154,420.96
		LESS: COB	5,477.28
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	148,943.68

TOTAL NUMBER OF ADMISSIONS 28

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	94		0	45,220.00		840.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	94		0	45,220.00		840.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	24		0	35,760.00		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	24		0	35,760.00		0.00
TOTAL ACCOMODATIONS	118		0	80,980.00		840.00

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	65,853.00	0.00	OTHER LAB	1,250.00	0.00
MED/SURG SUPPLY	22,788.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	16,801.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,075.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,385.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,425.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,650.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	26,457.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,456.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,113.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,699.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	9,765.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	538.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	528.00	120.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,112.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	211.00	0.00			
			TOTAL ANCILLARY	171,106.00	120.00
			TOTAL ACCOMODATIONS	80,980.00	840.00
			TOTAL CHARGES	252,086.00	960.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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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 05/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	546,308.50	ADJUSTMENTS	23,426.28
COVERED CHARGES	458,702.50	CONTRACTUAL ALLOW	228,492.63
NON-COVERD CHARGES	87,606.00	TOTAL MEDICAID LIAB	230,209.87
		LESS: COB	396.00
		LESS: COPAYMENT	1,788.00
		REIMBURSEMENT	228,025.87
		ALL OTHER	197,695.73
		FEE SCHEDULE-LAB	28,441.29
		INJECTABLE DRUGS	1,888.85
		TOTAL NUMBER OF CLAIMS	1,025

Report : CLM-0804-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

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WILLS MEMORIAL HOSPITAL
 120 GORDON ST
 WASHINGTON,GA 30673-1602

PROVIDER NUMBER
 000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,035.50	289.00	OTHER LAB	3,324.00	0.00
MED/SURG SUPPLY	18,870.00	208.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	103.00	EDUCATION & TRAINING	0.00	20.00
RADIOLOGY-DIAGNOSTIC	27,307.00	276.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	66,462.00	9,944.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,975.00	4,765.00	FEE SCHEDULE LAB	130,346.00	33,400.00
EKG/ECG	8,789.00	840.00	MRI SERVICES	29,750.00	0.00
IV THERAPY	245.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	21,335.00	5,440.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,379.00	2,366.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	63,398.00	13,102.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,240.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,082.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	345.00	185.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	635.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	956.00
OTHER IMAGING SERVICE	15,898.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,039.00	240.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,334.00	6,613.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	22,800.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,749.00	8,224.00			
			TOTAL ANCILLARY	458,702.50	87,606.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	458,702.50	87,606.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
7045	2213267005235	09/01/13 - 09/01/13	09/30/13	0.00	956.00	0.00	0.00	0.00
TOTAL				0.00	956.00	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 05/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,473.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,994.00	CONTRACTUAL ALLOW	1,407.03
NON-COVERD CHARGES	1,479.00	TOTAL MEDICAID LIAB	2,586.97
		LESS: COB	2,572.95
		LESS: COPAYMENT	14.02
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 11

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 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	480.00	0.00	OTHER LAB	659.00	0.00
MED/SURG SUPPLY	146.00	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	689.00	446.00
EKG/ECG	210.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	850.00	25.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	389.00	1,008.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	323.00	0.00			
			TOTAL ANCILLARY	3,994.00	1,479.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,994.00	1,479.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/13 THROUGH 04/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,199.00	ADJUSTMENTS	50.00
COVERED CHARGES	11,877.00	CONTRACTUAL ALLOW	9,902.00
NON-COVERD CHARGES	322.00	TOTAL MEDICAID LIAB	1,975.00
		LESS: COB	0.00
		LESS: COPAYMENT	72.00
		REIMBURSEMENT	1,903.00
		TOTAL NUMBER OF CLAIMS	40

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 05/01/13 THROUGH 04/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,307.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	277.00	6.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	167.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	885.00	151.00
EKG/ECG	105.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,577.00	165.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	224.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	335.00	0.00			
			TOTAL ANCILLARY	11,877.00	322.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,877.00	322.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/13	THROUGH	04/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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	05/01/13	THROUGH	04/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

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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	05/01/13	THROUGH	04/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

BARROW REGIONAL MEDICAL CENTER
 316 N BROAD ST
 WINDER,GA 30680-2150

PROVIDER NUMBER 000002098A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,028,402.61	ADJUSTMENTS	89,975.78
COVERED CHARGES	10,297,673.68	CONTRACTUAL ALLOW	7,995,292.30
NON-COVERD CHARGES	730,728.93	TOTAL MEDICAID LIAB	2,302,381.38
		LESS: COB	8,409.01
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,293,972.37

TOTAL NUMBER OF ADMISSIONS 265

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	321		335	149,763.41		354,915.60
ROUTINE NURSERY	23		0	9,126.60		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	344		335	158,890.01		354,915.60
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	320		26	441,759.18		36,245.82
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	320		26	441,759.18		36,245.82
TOTAL ACCOMODATIONS	664		361	600,649.19		391,161.42

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

BARROW REGIONAL MEDICAL CENTER
 316 N BROAD ST
 WINDER,GA 30680-2150

PROVIDER NUMBER
 000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,667,464.84	0.00	OTHER LAB	67,355.13	0.00
MED/SURG SUPPLY	382,853.76	1.42	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,336,331.66	0.00	EDUCATION & TRAINING	270.40	0.00
RADIOLOGY-DIAGNOSTIC	299,426.97	38,620.34	OTHER THERAPEUTIC SVC	0.00	263,999.13
CT SCAN	776,155.59	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	128,417.53	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	108,506.10	0.00	MRI SERVICES	76,059.16	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,615,895.99	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	22,359.73	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	790,755.14	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	429,830.56	0.00	AMBULANCE	0.00	0.00
GI SERVICES	83,098.16	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	487,089.96	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	102,610.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	170.78	0.00	INJECTABLE DRUGS	214.61	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,177.92	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	20,165.63	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	17,236.20	3,038.24	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	221.51	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	983,544.67	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	4,614.64
OTHER IMAGING SERVICE	89,154.28	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	60,796.53	23,065.20			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	73,454.46	6,228.54			
AUDIOLOGY	190.41	0.00			
CARDIOLOGY	63,920.98	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,295.43	0.00			
			TOTAL ANCILLARY	9,697,024.49	339,567.51
			TOTAL ACCOMODATIONS	600,649.19	391,161.42
			TOTAL CHARGES	10,297,673.68	730,728.93

Report : CLM-0800-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

Run Date: 07/15/2015
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BARROW REGIONAL MEDICAL CENTER
316 N BROAD ST
WINDER,GA 30680-2150

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014205037182	07/14/14 - 07/17/14	07/28/14	0.00	4,614.64	0.00	0.00	0.00
TOTAL				0.00	4,614.64	0.00	0.00	0.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

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BARROW REGIONAL MEDICAL CENTER
 316 N BROAD ST
 WINDER,GA 30680-2150

PROVIDER NUMBER
 000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	48,495.85	ADJUSTMENTS	0.00
COVERED CHARGES	47,307.95	CONTRACTUAL ALLOW	41,651.95
NON-COVERD CHARGES	1,187.90	TOTAL MEDICAID LIAB	5,656.00
		LESS: COB	5,656.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	10		0	4,560.00		1,187.90
ROUTINE NURSERY	0		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	4,560.00		1,187.90
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	4,560.00		1,187.90

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

BARROW REGIONAL MEDICAL CENTER
 316 N BROAD ST
 WINDER,GA 30680-2150

PROVIDER NUMBER
 000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,608.63	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	429.37	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,247.32	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	19,501.82	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,009.65	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,400.98	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,550.18	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	42,747.95	0.00
			TOTAL ACCOMODATIONS	4,560.00	1,187.90
			TOTAL CHARGES	47,307.95	1,187.90

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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BARROW REGIONAL MEDICAL CENTER
316 N BROAD ST
WINDER,GA 30680-2150

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,468,570.44	ADJUSTMENTS	339,361.95
COVERED CHARGES	11,191,117.03	CONTRACTUAL ALLOW	9,705,073.13
NON-COVERD CHARGES	2,277,453.41	TOTAL MEDICAID LIAB	1,486,043.90
		LESS: COB	2,514.52
		LESS: COPAYMENT	4,534.77
		REIMBURSEMENT	1,478,994.61
		ALL OTHER	1,374,042.49
		FEE SCHEDULE-LAB	85,653.77
		INJECTABLE DRUGS	19,298.35
		TOTAL NUMBER OF CLAIMS	3,338

BARROW REGIONAL MEDICAL CENTER
 316 N BROAD ST
 WINDER,GA 30680-2150

PROVIDER NUMBER
 000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,811.50	203,990.66	OTHER LAB	75,863.76	4,260.50
MED/SURG SUPPLY	44,936.17	8,322.57	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	973,960.77	23,592.19	OTHER THERAPEUTIC SVC	0.00	5,227.96
CT SCAN	1,933,497.29	751,764.31	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	110,359.00	7,065.76	FEE SCHEDULE LAB	1,275,497.53	258,070.13
EKG/ECG	116,224.33	9,711.72	MRI SERVICES	436,936.12	23,864.04
IV THERAPY	22,265.56	4,313.66	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	632,958.45	231,231.34	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	69,902.12	45,682.91	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	318,032.21	219,296.90	AMBULANCE	0.00	0.00
GI SERVICES	260,676.26	37,809.37	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,735,077.02	67,871.68	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	190,530.02	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	277,870.30	193,862.91
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	882.53	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	3,750.87	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	27,120.93	35,691.44
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	250,230.85	53,535.01			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	22,229.18	17,547.33			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	149,251.23	59,942.68			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	55,865.56	9,067.32			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,247.10	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	206,773.77	1,097.62			
			TOTAL ANCILLARY	11,191,117.03	2,277,453.41
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,191,117.03	2,277,453.41

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BARROW REGIONAL MEDICAL CENTER
316 N BROAD ST
WINDER,GA 30680-2150

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	87,046.17	ADJUSTMENTS	0.00
COVERED CHARGES	75,595.25	CONTRACTUAL ALLOW	57,651.58
NON-COVERD CHARGES	11,450.92	TOTAL MEDICAID LIAB	17,943.67
		LESS: COB	17,940.67
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 29

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BARROW REGIONAL MEDICAL CENTER
 316 N BROAD ST
 WINDER,GA 30680-2150

PROVIDER NUMBER
 000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	1,660.95	OTHER LAB	2,116.14	0.00
MED/SURG SUPPLY	351.17	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,926.96	0.00	OTHER THERAPEUTIC SVC	0.00	237.12
CT SCAN	4,075.17	7,993.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,477.00	0.00	FEE SCHEDULE LAB	9,069.36	655.11
EKG/ECG	3,149.55	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	646.31	520.25	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	39,404.44	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	3,807.57	383.89
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	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,277.94	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	293.64	0.00			
			TOTAL ANCILLARY	75,595.25	11,450.92
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	75,595.25	11,450.92

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
Run Time: 00:09:58
Page: 10

BARROW REGIONAL MEDICAL CENTER
316 N BROAD ST
WINDER,GA 30680-2150

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,192,062.28	ADJUSTMENTS	1,288.56
COVERED CHARGES	1,092,070.65	CONTRACTUAL ALLOW	1,064,883.83
NON-COVERD CHARGES	99,991.63	TOTAL MEDICAID LIAB	27,186.82
		LESS: COB	0.00
		LESS: COPAYMENT	921.00
		REIMBURSEMENT	26,265.82
		TOTAL NUMBER OF CLAIMS	486

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

BARROW REGIONAL MEDICAL CENTER
 316 N BROAD ST
 WINDER,GA 30680-2150

PROVIDER NUMBER
 000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	221.61	12,992.49	OTHER LAB	3,019.37	0.00
MED/SURG SUPPLY	2,504.58	4.32	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	65,815.62	0.00	OTHER THERAPEUTIC SVC	0.00	195.02
CT SCAN	87,240.40	57,990.20	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	101,585.80	16,792.90
EKG/ECG	8,931.85	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	621.80	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	2,432.48	2,294.01	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	790,071.95	514.83	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	15,873.56	8,100.51
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	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,351.26	1,107.35			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,400.37	0.00			
			TOTAL ANCILLARY	1,092,070.65	99,991.63
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,092,070.65	99,991.63

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
Run Time: 00:10:04
Page: 12

BARROW REGIONAL MEDICAL CENTER
316 N BROAD ST
WINDER,GA 30680-2150

PROVIDER NUMBER
000002098A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	39,586.43	ADJUSTMENTS	0.00
COVERED CHARGES	33,361.34	CONTRACTUAL ALLOW	24,386.75
NON-COVERD CHARGES	6,225.09	TOTAL MEDICAID LIAB	8,974.59
		LESS: COB	8,956.59
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	13

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
 Run Time: 00:10:04
 Page: 13

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BARROW REGIONAL MEDICAL CENTER
 316 N BROAD ST
 WINDER,GA 30680-2150

PROVIDER NUMBER
 000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	32.44	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	688.59	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,814.87	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,307.91	131.58
EKG/ECG	367.87	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,974.94	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5.34	1,094.56
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,016.69	1,151.64			
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	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	33,361.34	6,225.09
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	33,361.34	6,225.09

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
Run Time: 00:10:06
Page: 14

SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BARROW REGIONAL MEDICAL CENTER
316 N BROAD ST
WINDER,GA 30680-2150

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	120,330.00	ADJUSTMENTS	5,628.16
COVERED CHARGES	101,747.34	CONTRACTUAL ALLOW	85,363.39
NON-COVERD CHARGES	18,582.66	TOTAL MEDICAID LIAB	16,383.95
		LESS: COB	0.00
		LESS: COPAYMENT	25.15
		REIMBURSEMENT	16,358.80

TOTAL NUMBER OF CLAIMS 3

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BARROW REGIONAL MEDICAL CENTER
 316 N BROAD ST
 WINDER,GA 30680-2150

PROVIDER NUMBER
 000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	3,453.87	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,964.68	2,829.19	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,019.98	0.00	OTHER THERAPEUTIC SVC	0.00	86.22
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,119.05	168.28
EKG/ECG	367.87	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	64,708.88	1,172.17	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,113.19	4.92	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,166.47	8,670.58	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,141.93	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,887.75	2,197.43
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	8,764.04	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,493.50	0.00			
			TOTAL ANCILLARY	101,747.34	18,582.66
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	101,747.34	18,582.66

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
Run Time: 00:10:08
Page: 16

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BARROW REGIONAL MEDICAL CENTER
316 N BROAD ST
WINDER,GA 30680-2150

PROVIDER NUMBER
000002098A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
 Run Time: 00:10:16
 Page: 1

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 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	354,347.62	ADJUSTMENTS	2,609.93
COVERED CHARGES	353,419.62	CONTRACTUAL ALLOW	162,180.42
NON-COVERD CHARGES	928.00	TOTAL MEDICAID LIAB	191,239.20
		LESS: COB	1,655.80
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	189,583.40

TOTAL NUMBER OF ADMISSIONS 43

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	120		0	63,600.00		320.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	120		0	63,600.00		320.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	120		0	63,600.00		320.00

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
 Run Time: 00:10:16
 Page: 2

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 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47,964.54	0.00	OTHER LAB	742.00	0.00
MED/SURG SUPPLY	62,198.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	60,345.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,554.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,725.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	866.06	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	7,075.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,776.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,862.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	38,552.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20,560.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	223.02	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,623.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,160.00	608.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,074.00	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	1,520.00	0.00			
			TOTAL ANCILLARY	289,819.62	608.00
			TOTAL ACCOMODATIONS	63,600.00	320.00
			TOTAL CHARGES	353,419.62	928.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
Run Time: 00:10:22
Page: 3

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	08/01/13	THROUGH	07/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
Run Time: 00:10:22
Page: 4

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 08/01/13 THROUGH 07/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,277,690.12	ADJUSTMENTS	33,442.35
COVERED CHARGES	1,197,751.00	CONTRACTUAL ALLOW	828,913.79
NON-COVERD CHARGES	79,939.12	TOTAL MEDICAID LIAB	368,837.21
		LESS: COB	529.63
		LESS: COPAYMENT	756.00
		REIMBURSEMENT	367,551.58
		ALL OTHER	339,355.44
		FEE SCHEDULE-LAB	23,556.93
		INJECTABLE DRUGS	4,639.21
		TOTAL NUMBER OF CLAIMS	1,146

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 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	43,171.00	410.00	OTHER LAB	10,294.00	0.00
MED/SURG SUPPLY	71,520.00	320.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	84,543.00	1,095.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	154,061.00	7,210.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,104.00	5,453.12	FEE SCHEDULE LAB	257,396.00	51,793.00
EKG/ECG	21,370.00	1,540.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,326.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,184.00	238.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,089.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	477,454.00	5,335.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,764.00	17.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	540.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	19,821.00	5,418.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,250.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	10,148.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	10,110.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,146.00	570.00			
			TOTAL ANCILLARY	1,197,751.00	79,939.12
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,197,751.00	79,939.12

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

Run Date: 07/15/2015
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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 08/01/13 THROUGH 07/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,940.00	ADJUSTMENTS	0.00
COVERED CHARGES	13,458.00	CONTRACTUAL ALLOW	5,926.54
NON-COVERD CHARGES	1,482.00	TOTAL MEDICAID LIAB	7,531.46
		LESS: COB	7,522.63
		LESS: COPAYMENT	8.83
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 16

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 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	496.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,103.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,102.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,755.00	1,242.00
EKG/ECG	440.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	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	5,356.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	142.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	240.00			
			TOTAL ANCILLARY	13,458.00	1,482.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,458.00	1,482.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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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 08/01/13 THROUGH 07/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	130,353.00	ADJUSTMENTS	144.00
COVERED CHARGES	126,977.00	CONTRACTUAL ALLOW	117,877.00
NON-COVERD CHARGES	3,376.00	TOTAL MEDICAID LIAB	9,100.00
		LESS: COB	0.00
		LESS: COPAYMENT	360.00
		REIMBURSEMENT	8,740.00
		TOTAL NUMBER OF CLAIMS	182

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 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,701.00	55.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,287.00	186.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,191.00	244.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,897.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	14,203.00	2,426.00
EKG/ECG	880.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	168.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	87,362.00	465.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,678.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,610.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	126,977.00	3,376.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	126,977.00	3,376.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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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 08/01/13 THROUGH 07/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	356.00	ADJUSTMENTS	0.00
COVERED CHARGES	356.00	CONTRACTUAL ALLOW	213.10
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	142.90
		LESS: COB	142.90
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 08/01/13 THROUGH 07/31/14
 ADMISSION DATES 00/00/00 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	356.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	356.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	356.00	0.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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	08/01/13	THROUGH	07/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
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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	08/01/13	THROUGH	07/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

MONROE HMA INC
 2151 W SPRING ST
 MONROE,GA 30655-3115

PROVIDER NUMBER 000020677A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,801,537.36	ADJUSTMENTS	13,440.34
COVERED CHARGES	8,693,657.56	CONTRACTUAL ALLOW	6,367,319.53
NON-COVERD CHARGES	107,879.80	TOTAL MEDICAID LIAB	2,326,338.03
		LESS: COB	19,108.86
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,307,229.17

TOTAL NUMBER OF ADMISSIONS 295

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	380		0	205,801.60		12,666.69
ROUTINE NURSERY	59		0	16,394.13		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	439		0	222,195.73		12,666.69
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	633		0	678,676.98		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	633		0	678,676.98		0.00
TOTAL ACCOMODATIONS	1,072		0	900,872.71		12,666.69

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

MONROE HMA INC
 2151 W SPRING ST
 MONROE,GA 30655-3115

PROVIDER NUMBER
 000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,344,368.07	0.00	OTHER LAB	122,345.60	0.00
MED/SURG SUPPLY	173,758.05	422.49	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,359,773.27	0.00	EDUCATION & TRAINING	1,396.15	0.00
RADIOLOGY-DIAGNOSTIC	274,015.87	4,192.26	OTHER THERAPEUTIC SVC	0.00	10,796.40
CT SCAN	780,456.05	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	47,713.21	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	110,599.38	0.00	MRI SERVICES	86,853.11	0.00
IV THERAPY	295.98	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	877,510.73	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	33,376.65	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	342,720.84	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	489,911.33	0.00	AMBULANCE	0.00	0.00
GI SERVICES	93,159.27	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	682,700.94	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	169,595.61	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	15,974.54	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	16,175.51	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	25,226.72	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	14,648.71	2,921.40	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	311.91	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	33,863.56	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	37,665.87
OTHER IMAGING SERVICE	99,438.59	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	50,112.28	30,413.09			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	88,038.87	8,801.60			
AUDIOLOGY	3,872.82	0.00			
CARDIOLOGY	432,154.05	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	9,449.94	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,967.24	0.00			
			TOTAL ANCILLARY	7,792,784.85	95,213.11
			TOTAL ACCOMODATIONS	900,872.71	12,666.69
			TOTAL CHARGES	8,693,657.56	107,879.80

Report : CLM-0800-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

Run Date: 07/15/2015
Run Time: 00:10:46
Page: 3

MONROE HMA INC
2151 W SPRING ST
MONROE,GA 30655-3115

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013289019284	10/05/13 - 10/13/13	10/21/13	0.00	4,706.60	0.00	0.00	0.00
615	2013313023413	11/03/13 - 11/05/13	11/18/13	0.00	4,706.60	0.00	0.00	0.00
615	2014014016803	01/07/14 - 01/08/14	01/20/14	0.00	4,706.60	0.00	0.00	0.00
615	2014063020905	02/23/14 - 02/27/14	03/10/14	0.00	4,719.67	0.00	0.00	0.00
615	2014066038791	02/28/14 - 03/04/14	03/10/14	0.00	4,706.60	0.00	0.00	0.00
615	2014074023644	03/09/14 - 03/12/14	03/24/14	0.00	4,706.60	0.00	0.00	0.00
615	2014077031043	03/08/14 - 03/14/14	03/24/14	0.00	4,706.60	0.00	0.00	0.00
615	2014296046937	05/27/14 - 05/29/14	10/27/14	0.00	4,706.60	0.00	0.00	0.00
TOTAL				0.00	37,665.87	0.00	0.00	0.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
 Run Time: 00:11:04
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SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

MONROE HMA INC
 2151 W SPRING ST
 MONROE,GA 30655-3115

PROVIDER NUMBER
 000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,899.23	ADJUSTMENTS	0.00
COVERED CHARGES	16,899.23	CONTRACTUAL ALLOW	10,769.23
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	6,130.00
		LESS: COB	6,130.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	4		0	1,997.76		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	4		0	1,997.76		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	1,997.76		0.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

MONROE HMA INC
 2151 W SPRING ST
 MONROE,GA 30655-3115

PROVIDER NUMBER
 000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,495.55	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	423.82	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,077.47	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,736.80	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,800.29	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,123.30	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	244.24	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	14,901.47	0.00
			TOTAL ACCOMODATIONS	1,997.76	0.00
			TOTAL CHARGES	16,899.23	0.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
Run Time: 00:11:05
Page: 6

MONROE HMA INC
2151 W SPRING ST
MONROE,GA 30655-3115

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,037,872.91	ADJUSTMENTS	284,704.11
COVERED CHARGES	11,832,758.01	CONTRACTUAL ALLOW	9,871,809.19
NON-COVERD CHARGES	2,205,114.90	TOTAL MEDICAID LIAB	1,960,948.82
		LESS: COB	5,344.39
		LESS: COPAYMENT	3,480.00
		REIMBURSEMENT	1,952,124.43
		ALL OTHER	1,827,795.71
		FEE SCHEDULE-LAB	116,961.05
		INJECTABLE DRUGS	7,367.67
		TOTAL NUMBER OF CLAIMS	3,873

MONROE HMA INC
 2151 W SPRING ST
 MONROE,GA 30655-3115

PROVIDER NUMBER
 000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	113.88	259,741.38	OTHER LAB	204,826.92	0.00
MED/SURG SUPPLY	98,620.82	10,325.26	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	240.00
RADIOLOGY-DIAGNOSTIC	570,138.60	14,529.85	OTHER THERAPEUTIC SVC	0.00	70,147.83
CT SCAN	1,125,516.23	960,341.31	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	23,945.00	4,310.35	FEE SCHEDULE LAB	1,526,181.46	255,548.23
EKG/ECG	193,495.95	8,583.70	MRI SERVICES	379,280.93	31,932.08
IV THERAPY	17,843.44	6,530.67	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	580,843.01	151,475.36	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	40,611.06	11,535.44	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	478,083.34	886.08	AMBULANCE	0.00	0.00
GI SERVICES	205,292.45	38,327.47	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,631,476.39	149,316.70	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	351,175.69	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	201,192.07	135,017.96
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,474.19	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	250.00	2,408.42	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,018.98	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	4,117.06	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,544.76	36,475.59
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	489,939.76	5,261.89			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,327.96	589.22			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	150,980.96	15,397.35			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	275,662.59	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,397.34	1,397.34			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	281,017.40	28,185.19			
			TOTAL ANCILLARY	11,832,758.01	2,205,114.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,832,758.01	2,205,114.90

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

Run Date: 07/15/2015
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE HMA INC
2151 W SPRING ST
MONROE,GA 30655-3115

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	150,544.67	ADJUSTMENTS	0.00
COVERED CHARGES	113,827.40	CONTRACTUAL ALLOW	49,624.95
NON-COVERD CHARGES	36,717.27	TOTAL MEDICAID LIAB	64,202.45
		LESS: COB	64,192.18
		LESS: COPAYMENT	10.27
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 36

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE HMA INC
 2151 W SPRING ST
 MONROE,GA 30655-3115

PROVIDER NUMBER
 000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	2,251.16	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	264.41	22.52	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,758.04	0.00	OTHER THERAPEUTIC SVC	0.00	593.39
CT SCAN	0.00	26,393.22	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	15,659.28	859.24
EKG/ECG	1,928.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	978.70	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,174.01	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,447.58	604.18	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,302.32	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	63,227.72	2,338.18	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,731.66	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,405.48	1,066.35
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,389.06	580.82			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	560.64	2,008.21			
			TOTAL ANCILLARY	113,827.40	36,717.27
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	113,827.40	36,717.27

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE HMA INC
 2151 W SPRING ST
 MONROE,GA 30655-3115

PROVIDER NUMBER
 000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	20,548.25	OTHER LAB	5,080.51	0.00
MED/SURG SUPPLY	502.53	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	38,493.09	0.00	OTHER THERAPEUTIC SVC	0.00	1,808.16
CT SCAN	65,287.08	51,517.51	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	110,639.52	11,432.18
EKG/ECG	13,858.71	0.00	MRI SERVICES	3,912.39	4,894.86
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,674.63	968.14	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	703,350.90	2,263.18	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	24,258.60	3,834.14
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	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	44,551.56	4,989.06			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,135.21	0.00			
			TOTAL ANCILLARY	1,015,744.73	102,255.48
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,015,744.73	102,255.48

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE HMA INC
2151 W SPRING ST
MONROE,GA 30655-3115

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,457.69	ADJUSTMENTS	0.00
COVERED CHARGES	15,781.86	CONTRACTUAL ALLOW	12,960.85
NON-COVERD CHARGES	675.83	TOTAL MEDICAID LIAB	2,821.01
		LESS: COB	2,815.01
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	6

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE HMA INC
 2151 W SPRING ST
 MONROE,GA 30655-3115

PROVIDER NUMBER
 000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	335.60	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	3,332.81	244.92
EKG/ECG	472.67	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,155.35	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	26.28	95.31
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	3,794.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	15,781.86	675.83
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,781.86	675.83

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MONROE HMA INC
2151 W SPRING ST
MONROE,GA 30655-3115

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/13 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	700,008.01	ADJUSTMENTS	15,826.04
COVERED CHARGES	619,799.10	CONTRACTUAL ALLOW	540,036.16
NON-COVERD CHARGES	80,208.91	TOTAL MEDICAID LIAB	79,762.94
		LESS: COB	0.00
		LESS: COPAYMENT	63.00
		REIMBURSEMENT	79,699.94
		TOTAL NUMBER OF CLAIMS	15

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MONROE HMA INC
 2151 W SPRING ST
 MONROE,GA 30655-3115

PROVIDER NUMBER
 000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/13 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	8,637.31	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	41,911.48	415.32	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,863.89	0.00	OTHER THERAPEUTIC SVC	0.00	11,003.15
CT SCAN	6,712.62	2,953.85	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,008.85	FEE SCHEDULE LAB	15,417.96	753.60
EKG/ECG	983.91	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,035.93	295.98	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	209,059.20	38,169.30	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	986.42	87.73	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	127,874.49	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	51,909.10	263.11	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	42,510.11	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,833.13	6,891.16
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,556.58	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,481.55	6,382.28
LITHOTRIpsy	82,244.90	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,559.04	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,965.64	1,178.44			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,449.73	612.25			
			TOTAL ANCILLARY	619,799.10	80,208.91
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	619,799.10	80,208.91

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MONROE HMA INC
2151 W SPRING ST
MONROE,GA 30655-3115

PROVIDER NUMBER
000020677A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/13	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

CHESTATEE REGIONAL HOSPITAL
 227 MOUNTAIN DR
 DAHLONEGA,GA 30533-1606

PROVIDER NUMBER 000081232A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,707,834.46	ADJUSTMENTS	55,482.38
COVERED CHARGES	1,686,672.46	CONTRACTUAL ALLOW	1,099,973.54
NON-COVERD CHARGES	21,162.00	TOTAL MEDICAID LIAB	586,698.92
		LESS: COB	11,156.79
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	575,542.13

TOTAL NUMBER OF ADMISSIONS 64

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	191		0	125,020.00		19,886.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	191		0	125,020.00		19,886.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	30		0	36,090.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	30		0	36,090.00		0.00
TOTAL ACCOMODATIONS	221		0	161,110.00		19,886.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

CHESTATEE REGIONAL HOSPITAL
 227 MOUNTAIN DR
 DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
 000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	323,777.00	0.00	OTHER LAB	3,146.00	0.00
MED/SURG SUPPLY	124,430.36	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	183,326.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,496.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	94,781.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,879.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	5,562.00	0.00	MRI SERVICES	7,114.00	0.00
IV THERAPY	10,873.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	92,360.00	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	75,125.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	59,998.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	76,438.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,123.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	182,144.60	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	199,403.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,347.00	0.00			
BLOOD	1,380.00	0.00			
BLOOD STORAGE & PRO.	10,434.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,084.00	270.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,375.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,966.00	0.00			
			TOTAL ANCILLARY	1,525,562.46	1,276.00
			TOTAL ACCOMODATIONS	161,110.00	19,886.00
			TOTAL CHARGES	1,686,672.46	21,162.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

CHESTATEE REGIONAL HOSPITAL
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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CHESTATEE REGIONAL HOSPITAL
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,018,526.44	ADJUSTMENTS	174,164.43
COVERED CHARGES	1,891,841.32	CONTRACTUAL ALLOW	1,525,711.96
NON-COVERD CHARGES	126,685.12	TOTAL MEDICAID LIAB	366,129.36
		LESS: COB	1,174.06
		LESS: COPAYMENT	1,941.00
		REIMBURSEMENT	363,014.30
		ALL OTHER	332,630.10
		FEE SCHEDULE-LAB	27,088.84
		INJECTABLE DRUGS	3,295.36
		TOTAL NUMBER OF CLAIMS	1,047

SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

CHESTATEE REGIONAL HOSPITAL
 227 MOUNTAIN DR
 DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
 000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	112,945.00	147.00	OTHER LAB	10,092.00	0.00
MED/SURG SUPPLY	113,021.36	100.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	274.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	114,299.00	553.00	OTHER THERAPEUTIC SVC	0.00	7,614.00
CT SCAN	250,384.00	5,451.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	358,263.60	85,310.10
EKG/ECG	15,862.00	824.00	MRI SERVICES	16,956.00	0.00
IV THERAPY	16,399.00	212.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	115,160.04	2,311.02	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	26,139.00	1,004.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	89,233.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	377,393.00	6,411.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,685.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	60,887.04	13,942.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,270.00	621.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	90,956.00	165.00	IMPL DEV CHARGE PATIENTS	20,465.28	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	50,220.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	12,936.00	1,694.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	788.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	11,480.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,007.00	52.00			
			TOTAL ANCILLARY	1,891,841.32	126,685.12
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,891,841.32	126,685.12

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

Run Date: 07/15/2015
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHESTATEE REGIONAL HOSPITAL
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,698.00	ADJUSTMENTS	0.00
COVERED CHARGES	14,280.00	CONTRACTUAL ALLOW	7,662.00
NON-COVERD CHARGES	9,418.00	TOTAL MEDICAID LIAB	6,618.00
		LESS: COB	6,612.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 13

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHESTATEE REGIONAL HOSPITAL
 227 MOUNTAIN DR
 DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
 000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	468.00	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	877.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	8,112.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,933.00	452.00
EKG/ECG	1,378.00	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	274.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,349.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	78.00	854.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	660.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	14,280.00	9,418.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,280.00	9,418.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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CHESTATEE REGIONAL HOSPITAL
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	86,830.80	ADJUSTMENTS	967.92
COVERED CHARGES	80,519.00	CONTRACTUAL ALLOW	75,090.77
NON-COVERD CHARGES	6,311.80	TOTAL MEDICAID LIAB	5,428.23
		LESS: COB	0.00
		LESS: COPAYMENT	183.01
		REIMBURSEMENT	5,245.22
		TOTAL NUMBER OF CLAIMS	98

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

CHESTATEE REGIONAL HOSPITAL
 227 MOUNTAIN DR
 DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
 000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,349.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,233.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,732.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,103.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,953.00	6,269.80
EKG/ECG	1,236.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	274.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	45,054.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,124.00	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	1,461.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	80,519.00	6,311.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	80,519.00	6,311.80

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHESTATEE REGIONAL HOSPITAL
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,822.00	ADJUSTMENTS	0.00
COVERED CHARGES	7,423.00	CONTRACTUAL ALLOW	6,805.38
NON-COVERD CHARGES	399.00	TOTAL MEDICAID LIAB	617.62
		LESS: COB	614.62
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHESTATEE REGIONAL HOSPITAL
 227 MOUNTAIN DR
 DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
 000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	251.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	92.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	264.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,968.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,144.00	399.00
EKG/ECG	206.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,498.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,423.00	399.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,423.00	399.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII

Run Date: 07/15/2015
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHESTATEE REGIONAL HOSPITAL
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,046.08	ADJUSTMENTS	4,962.37
COVERED CHARGES	23,614.08	CONTRACTUAL ALLOW	18,645.71
NON-COVERD CHARGES	1,432.00	TOTAL MEDICAID LIAB	4,968.37
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	4,962.37

TOTAL NUMBER OF CLAIMS 1

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHESTATEE REGIONAL HOSPITAL
 227 MOUNTAIN DR
 DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
 000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,955.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,455.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	742.00
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	3,236.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,932.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	348.00	30.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,629.00	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	955.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	416.00	660.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,089.38	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	598.00	0.00			
			TOTAL ANCILLARY	23,614.08	1,432.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	23,614.08	1,432.00

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHESTATEE REGIONAL HOSPITAL
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF 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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,800,576.63	ADJUSTMENTS	12,937.08
COVERED CHARGES	3,690,370.01	CONTRACTUAL ALLOW	2,949,903.90
NON-COVERD CHARGES	110,206.62	TOTAL MEDICAID LIAB	740,466.11
		LESS: COB	12,872.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	727,593.91

TOTAL NUMBER OF ADMISSIONS 198

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	150		98	122,850.00		103,251.60
ROUTINE NURSERY	146		0	93,398.20		2,116.80
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	296		98	216,248.20		105,368.40
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	47		0	62,615.45		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	47		0	62,615.45		0.00
TOTAL ACCOMODATIONS	343		98	278,863.65		105,368.40

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	460,434.38	0.00	OTHER LAB	3,528.10	0.00
MED/SURG SUPPLY	41,486.34	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	571,393.32	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,165.13	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	92,327.10	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,515.68	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	11,821.12	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	572,899.41	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	384,127.03	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	71,764.77	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	89,345.36	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,614.30	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	131,690.81	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	35,485.77	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	8,215.09	0.00	INJECTABLE DRUGS	744,147.88	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,307.66	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,185.60	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	81,445.03	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,260.84	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	22,389.01	4,394.01			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,446.90	444.21			
AUDIOLOGY	10,083.25	0.00			
CARDIOLOGY	7,140.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,286.48	0.00			
			TOTAL ANCILLARY	3,411,506.36	4,838.22
			TOTAL ACCOMODATIONS	278,863.65	105,368.40
			TOTAL CHARGES	3,690,370.01	110,206.62

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
 Run Time: 00:12:35
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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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	46,097.37	ADJUSTMENTS	0.00
COVERED CHARGES	45,633.87	CONTRACTUAL ALLOW	31,505.97
NON-COVERD CHARGES	463.50	TOTAL MEDICAID LIAB	14,127.90
		LESS: COB	14,127.90
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5		0	4,095.00		463.50
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	5		0	4,095.00		463.50
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	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	4,095.00		463.50

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,266.73	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	119.91	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,017.81	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,763.32	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	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	11,738.92	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	233.67	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	398.51	0.00			
			TOTAL ANCILLARY	41,538.87	0.00
			TOTAL ACCOMODATIONS	4,095.00	463.50
			TOTAL CHARGES	45,633.87	463.50

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,132,160.79	ADJUSTMENTS	158,038.77
COVERED CHARGES	4,452,219.87	CONTRACTUAL ALLOW	3,945,270.53
NON-COVERD CHARGES	679,940.92	TOTAL MEDICAID LIAB	506,949.34
		LESS: COB	1,987.77
		LESS: COPAYMENT	1,170.12
		REIMBURSEMENT	503,791.45
		ALL OTHER	438,698.49
		FEE SCHEDULE-LAB	55,099.32
		INJECTABLE DRUGS	9,993.64

TOTAL NUMBER OF CLAIMS 1,265

Report : CLM-0804-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	220,204.02	20,458.43	OTHER LAB	104,208.17	0.00
MED/SURG SUPPLY	31,951.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	135,415.09	2,473.81	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	347,448.29	71,615.82	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	22,559.30	8,003.81	FEE SCHEDULE LAB	1,419,261.41	315,290.99
EKG/ECG	84,375.92	695.36	MRI SERVICES	111,657.21	2,882.42
IV THERAPY	8,443.10	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	377,048.58	68,316.67	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	942.47	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	42,824.93	2,092.32	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	115,619.20	0.00	AMBULANCE	0.00	0.00
GI SERVICES	89,750.83	25,833.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	695,830.79	7,114.90	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	78,983.42	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	296,744.25	116,309.35
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,079.57	3,990.39	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,339.77	956.41	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	11,597.70
LITHOTRIPSY	37,853.00	0.00	NO CC/INVALID REV CODE	0.00	5,108.42
OTHER IMAGING SERVICE	64,331.20	6,033.58			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,539.52	3,841.29			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	29,803.46	3,628.44			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	47,092.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	15,716.34	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	53,196.03	3,697.31			
			TOTAL ANCILLARY	4,452,219.87	679,940.92
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,452,219.87	679,940.92

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014239053910	08/22/14 - 08/22/14	09/01/14	0.00	2,226.00	0.00	0.00	0.00
615	2014252034200	09/05/14 - 09/05/14	09/15/14	0.00	2,882.42	0.00	0.00	0.00
TOTAL				0.00	5,108.42	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	46,695.43	ADJUSTMENTS	0.00
COVERED CHARGES	37,569.82	CONTRACTUAL ALLOW	19,543.16
NON-COVERD CHARGES	9,125.61	TOTAL MEDICAID LIAB	18,026.66
		LESS: COB	18,020.66
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 13

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,255.59	0.00	OTHER LAB	1,572.47	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	797.60	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,400.48	3,087.34	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	519.95	519.95	FEE SCHEDULE LAB	8,458.73	832.33
EKG/ECG	347.68	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,944.68	3,201.75	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	0.00	393.36
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	3,272.64	1,090.88			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	37,569.82	9,125.61
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	37,569.82	9,125.61

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	195,852.49	ADJUSTMENTS	161.82
COVERED CHARGES	175,623.91	CONTRACTUAL ALLOW	169,246.75
NON-COVERD CHARGES	20,228.58	TOTAL MEDICAID LIAB	6,377.16
		LESS: COB	0.00
		LESS: COPAYMENT	219.00
		REIMBURSEMENT	6,158.16
		TOTAL NUMBER OF CLAIMS	114

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,268.27	1,431.54	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,837.15	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,366.18	3,865.32	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	67,039.49	8,977.62
EKG/ECG	2,086.08	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	75,948.07	94.49	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	11,315.31	5,678.02
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	1,089.54	181.59	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,673.82	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	175,623.91	20,228.58
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	175,623.91	20,228.58

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,646.61	ADJUSTMENTS	0.00
COVERED CHARGES	9,151.35	CONTRACTUAL ALLOW	6,723.31
NON-COVERD CHARGES	495.26	TOTAL MEDICAID LIAB	2,428.04
		LESS: COB	2,425.04
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,536.60	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	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,074.24	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,540.51	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	495.26
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,151.35	495.26
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,151.35	495.26

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	526,773.63	ADJUSTMENTS	27,072.40
COVERED CHARGES	451,898.64	CONTRACTUAL ALLOW	397,723.84
NON-COVERD CHARGES	74,874.99	TOTAL MEDICAID LIAB	54,174.80
		LESS: COB	0.00
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	54,141.80
		TOTAL NUMBER OF CLAIMS	10

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,262.44	4,570.38	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	15,475.55	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	446.66	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,904.46	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	14,016.27	970.21
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	264,032.18	35,292.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	385.88	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	50,218.88	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,745.52	993.44	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	25,339.97	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	24,270.30	13,205.69
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	18,602.68
LITHOTRIPSY	18,926.50	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,589.92	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,284.11	1,240.09			
			TOTAL ANCILLARY	451,898.64	74,874.99
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	451,898.64	74,874.99

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
Run Time: 00:12:49
Page: 16

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	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
 Run Time: 00:12:56
 Page: 1

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,347,947.53	ADJUSTMENTS	85,644.20
COVERED CHARGES	2,269,351.77	CONTRACTUAL ALLOW	1,567,426.72
NON-COVERD CHARGES	78,595.76	TOTAL MEDICAID LIAB	701,925.05
		LESS: COB	3,970.31
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	697,954.74

TOTAL NUMBER OF ADMISSIONS 97

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	350		0	174,650.00		66,560.00
ROUTINE NURSERY	19		0	8,697.00		303.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	369		0	183,347.00		66,863.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	122		0	123,120.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	123,120.00		0.00
TOTAL ACCOMODATIONS	491		0	306,467.00		66,863.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	181,927.30	0.00	OTHER LAB	11,320.00	0.00
MED/SURG SUPPLY	188,379.20	5,645.30	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	280,533.64	380.00	EDUCATION & TRAINING	104.00	0.00
RADIOLOGY-DIAGNOSTIC	17,595.82	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	37,629.15	4,364.46	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	12,692.06	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	7,092.00	0.00	MRI SERVICES	29,269.47	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	323,238.72	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	17,400.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	43,499.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	53,562.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	8,862.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	29,095.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	6,494.00	0.00	INJECTABLE DRUGS	627,695.60	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,720.02	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	339.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	7,616.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	693.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	13,626.80	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,539.85	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	15,286.00	1,165.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	796.95	178.00			
AUDIOLOGY	2,152.00	0.00			
CARDIOLOGY	27,098.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,896.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,732.19	0.00			
			TOTAL ANCILLARY	1,962,884.77	11,732.76
			TOTAL ACCOMODATIONS	306,467.00	66,863.00
			TOTAL CHARGES	2,269,351.77	78,595.76

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

Run Date: 07/15/2015
 Run Time: 00:12:59
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	48,408.25	ADJUSTMENTS	0.00
COVERED CHARGES	46,960.25	CONTRACTUAL ALLOW	28,684.78
NON-COVERD CHARGES	1,448.00	TOTAL MEDICAID LIAB	18,275.47
		LESS: COB	18,275.47
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	8		0	3,992.00		1,448.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	8		0	3,992.00		1,448.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	8		0	3,992.00		1,448.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,587.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,268.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,054.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	243.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	197.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,081.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,078.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,788.00	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	2,179.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,549.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	744.00	0.00			
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	0.00	0.00			
			TOTAL ANCILLARY	42,968.25	0.00
			TOTAL ACCOMODATIONS	3,992.00	1,448.00
			TOTAL CHARGES	46,960.25	1,448.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
Run Time: 00:12:59
Page: 5

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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,231,280.53	ADJUSTMENTS	21,787.11
COVERED CHARGES	1,834,721.83	CONTRACTUAL ALLOW	1,448,024.60
NON-COVERD CHARGES	396,558.70	TOTAL MEDICAID LIAB	386,697.23
		LESS: COB	4,991.06
		LESS: COPAYMENT	908.69
		REIMBURSEMENT	380,797.48
		ALL OTHER	370,549.84
		FEE SCHEDULE-LAB	8,955.89
		INJECTABLE DRUGS	1,291.75

TOTAL NUMBER OF CLAIMS 329

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	56,373.50	95.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	139,015.05	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,287.03	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,805.35	8,291.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,002.09	FEE SCHEDULE LAB	109,091.70	11,623.00
EKG/ECG	9,850.00	591.00	MRI SERVICES	10,166.58	7,054.79
IV THERAPY	542.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	788,633.30	348,066.70	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,424.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	113,702.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	184,051.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,424.00	1,407.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	106,908.00	1,297.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,460.95	9,977.00
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	419.02	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	28,179.70	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	19,941.55	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,515.02	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	17,357.00	4,660.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,645.46	598.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,469.90	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	186,560.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,318.74	1,476.60			
			TOTAL ANCILLARY	1,834,721.83	396,558.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,834,721.83	396,558.70

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
Run Time: 00:13:02
Page: 7

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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,839.15	ADJUSTMENTS	0.00
COVERED CHARGES	11,679.15	CONTRACTUAL ALLOW	9,808.64
NON-COVERD CHARGES	9,160.00	TOTAL MEDICAID LIAB	1,870.51
		LESS: COB	1,861.51
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	343.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	404.50	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	1,302.00	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	0.00	7,797.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	838.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,451.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,448.00	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	1,885.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	110.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	414.70	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,686.00	1,165.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	796.95	178.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	11,679.15	9,160.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,679.15	9,160.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	529,610.81	ADJUSTMENTS	0.00
COVERED CHARGES	502,272.25	CONTRACTUAL ALLOW	413,799.30
NON-COVERD CHARGES	27,338.56	TOTAL MEDICAID LIAB	88,472.95
		LESS: COB	2,106.24
		LESS: COPAYMENT	69.00
		REIMBURSEMENT	86,297.71

TOTAL NUMBER OF CLAIMS 17

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,686.75	123.00	OTHER LAB	1,330.00	0.00
MED/SURG SUPPLY	49,955.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,519.69	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	558.06	FEE SCHEDULE LAB	6,434.00	413.00
EKG/ECG	788.00	591.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	273,381.50	25,443.50	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	53,279.00	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	25,456.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	838.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	13,223.85	0.00
LITHOTRIPSY	58,832.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	496.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,888.00	210.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,163.86	0.00			
			TOTAL ANCILLARY	502,272.25	27,338.56
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	502,272.25	27,338.56

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 07/01/14 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	549,091.39	ADJUSTMENTS	0.00
COVERED CHARGES	537,251.39	CONTRACTUAL ALLOW	378,721.69
NON-COVERD CHARGES	11,840.00	TOTAL MEDICAID LIAB	158,529.70
		LESS: COB	1,124.38
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	157,405.32

TOTAL NUMBER OF ADMISSIONS 25

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	65		0	32,435.00		11,840.00
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	65		0	32,435.00		11,840.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	57		0	61,260.00		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	57		0	61,260.00		0.00
TOTAL ACCOMODATIONS	122		0	93,695.00		11,840.00

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 07/01/14 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45,624.80	0.00	OTHER LAB	1,330.00	0.00
MED/SURG SUPPLY	31,578.35	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	85,952.00	0.00	EDUCATION & TRAINING	52.00	0.00
RADIOLOGY-DIAGNOSTIC	3,919.63	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,352.45	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,733.13	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,561.00	0.00	MRI SERVICES	6,329.82	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	52,729.42	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,742.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,251.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,441.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,476.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	190.00	0.00	INJECTABLE DRUGS	136,275.85	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	385.02	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	3,264.00	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	14,880.20	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,279.06	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,600.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,351.12	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,173.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,022.54	0.00			
			TOTAL ANCILLARY	443,556.39	0.00
			TOTAL ACCOMODATIONS	93,695.00	11,840.00
			TOTAL CHARGES	537,251.39	11,840.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 07/01/14 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
Run Time: 00:13:10
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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 07/01/14 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	560,684.51	ADJUSTMENTS	3,572.45
COVERED CHARGES	483,896.01	CONTRACTUAL ALLOW	398,350.96
NON-COVERD CHARGES	76,788.50	TOTAL MEDICAID LIAB	85,545.05
		LESS: COB	487.07
		LESS: COPAYMENT	276.00
		REIMBURSEMENT	84,781.98
		ALL OTHER	82,155.77
		FEE SCHEDULE-LAB	1,835.66
		INJECTABLE DRUGS	790.55

TOTAL NUMBER OF CLAIMS 76

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 07/01/14 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,249.80	360.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	47,743.10	15.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,394.78	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	21,096.79	5,460.56
EKG/ECG	2,503.15	591.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,474.09	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	228,933.00	53,664.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,651.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	42,175.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,831.00	3,635.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	369.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,513.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,714.90	220.00
RADIOLOGY THERAPEUTIC	19,991.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,906.10	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	11,162.90	11,483.40
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	437.22	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,375.21	1,359.54			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,143.85	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	32,992.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,239.12	0.00			
			TOTAL ANCILLARY	483,896.01	76,788.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	483,896.01	76,788.50

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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	07/01/14	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0808-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 07/01/14 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 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	224.49	0.00	OTHER THERAPEUTIC SVC	0.00	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	369.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	593.49	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	593.49	0.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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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	07/01/14	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 07/01/14 THROUGH 09/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	104,429.33	ADJUSTMENTS	0.00
COVERED CHARGES	104,232.33	CONTRACTUAL ALLOW	92,537.43
NON-COVERD CHARGES	197.00	TOTAL MEDICAID LIAB	11,694.90
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	11,679.90

TOTAL NUMBER OF CLAIMS 2

Report : CLM-0812-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 07/01/14 THROUGH 09/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,281.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	19,354.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	224.49	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,345.00	0.00
EKG/ECG	0.00	197.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	65,341.00	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	10,936.00	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	2,888.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	47.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,179.90	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	635.04	0.00			
			TOTAL ANCILLARY	104,232.33	197.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	104,232.33	197.00

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
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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	07/01/14	THROUGH	09/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,053,113.20	ADJUSTMENTS	456,994.43
COVERED CHARGES	2,828,658.20	CONTRACTUAL ALLOW	-669,761.19
NON-COVERD CHARGES	224,455.00	TOTAL MEDICAID LIAB	3,498,419.39
		LESS: COB	257.11
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,498,162.28

TOTAL NUMBER OF ADMISSIONS 874

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,519		8	2,088,635.00		224,455.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,519		8	2,088,635.00		224,455.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	3,519		8	2,088,635.00		224,455.00

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	154,072.27	0.00	OTHER LAB	478.01	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	229,048.70	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,202.06	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	938.08	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	899.08	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	106.99	0.00	INJECTABLE DRUGS	342,278.01	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	740,023.20	0.00
			TOTAL ACCOMODATIONS	2,088,635.00	224,455.00
			TOTAL CHARGES	2,828,658.20	224,455.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	130,387.94	ADJUSTMENTS	934.17
COVERED CHARGES	113,199.66	CONTRACTUAL ALLOW	87,073.96
NON-COVERD CHARGES	17,188.28	TOTAL MEDICAID LIAB	26,125.70
		LESS: COB	0.00
		LESS: COPAYMENT	609.00
		REIMBURSEMENT	25,516.70
		ALL OTHER	21,131.78
		FEE SCHEDULE-LAB	4,382.77
		INJECTABLE DRUGS	2.15
		TOTAL NUMBER OF CLAIMS	277

PREMIER HEALTHCARE INVESTMENTS
 509 SUMTER STREET
 MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
 000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	512.18	0.00	OTHER LAB	19,421.39	0.00
MED/SURG SUPPLY	7.04	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	219.64	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	39,278.14	3,410.67	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,360.82	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	31,437.65	12,235.83
EKG/ECG	449.54	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	1,313.82	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	23.02	8.32
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	6,956.07	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,284.04	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	469.77	0.00			
			TOTAL ANCILLARY	113,199.66	17,188.28
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	113,199.66	17,188.28

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

Run Date: 07/15/2015
Run Time: 00:13:28
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	166.29	ADJUSTMENTS	0.00
COVERED CHARGES	166.29	CONTRACTUAL ALLOW	75.77
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	90.52
		LESS: COB	87.52
		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

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 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	166.29	0.00
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	166.29	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	166.29	0.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
Run Time: 00:13:28
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PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
Run Time: 00:13:28
Page: 9

PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
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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	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF 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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,076,019.78	ADJUSTMENTS	1,137,609.86
COVERED CHARGES	25,442,242.23	CONTRACTUAL ALLOW	17,916,096.27
NON-COVERD CHARGES	1,633,777.55	TOTAL MEDICAID LIAB	7,526,145.96
		LESS: COB	101,734.89
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,424,411.07

TOTAL NUMBER OF ADMISSIONS 907

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,746		5	2,084,292.00		753,982.00
ROUTINE NURSERY	544		5	475,011.00		15,869.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		2,499.00
TOTAL ROUTINE	4,290		10	2,559,303.00		772,350.00
SPECIAL CARE SERVICES						
CCU	514		0	1,069,440.00		0.00
ICU	178		0	401,830.00		0.00
NICU	72		0	147,117.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	764		0	1,618,387.00		0.00
TOTAL ACCOMODATIONS	5,054		10	4,177,690.00		772,350.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,692,012.45	251,007.54	OTHER LAB	161,645.00	0.00
MED/SURG SUPPLY	720,688.80	28,250.51	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,949,290.93	162,683.00	EDUCATION & TRAINING	5,579.50	0.00
RADIOLOGY-DIAGNOSTIC	530,843.00	3,556.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	953,747.00	69,135.00	SPECIAL CHARGES	2,891.14	0.00
PHYSICAL THERAPY	101,658.02	4,204.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	147,166.79	666.00	MRI SERVICES	404,802.00	0.00
IV THERAPY	265,907.00	2,298.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,573,401.00	65,672.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	354,760.00	5,118.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	961,629.00	24,090.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	309,544.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	200,095.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	598,933.00	14,988.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	301,153.00	701.00	DRUG-SPECIFIC/HOME IV	0.00	42,911.00
LABORATORY PATHOLOGIC	151,167.00	0.00	INJECTABLE DRUGS	227,785.00	0.00
RADIOLOGY THERAPEUTIC	37,899.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	44,055.00	2,485.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	29,723.05	3,886.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	64,032.00	702.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	25,998.00	33,380.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	948,484.55	49,847.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	17,871.00
OTHER IMAGING SERVICE	214,759.00	435.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	369,281.00	21,244.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	269,027.00	53,207.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	584,291.00	847.00			
AMBULATORY SURGERY	1,776.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	28,632.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	31,896.00	2,243.00			
			TOTAL ANCILLARY	21,264,552.23	861,427.55
			TOTAL ACCOMODATIONS	4,177,690.00	772,350.00
			TOTAL CHARGES	25,442,242.23	1,633,777.55

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013214088307	07/19/13 - 07/20/13	08/12/13	0.00	2,553.00	0.00	0.00	0.00
615	2013217032985	07/20/13 - 07/31/13	08/12/13	0.00	2,553.00	0.00	0.00	0.00
615	2013268062136	09/18/13 - 09/19/13	09/30/13	0.00	2,553.00	0.00	0.00	0.00
615	2013273033057	09/21/13 - 09/24/13	10/07/13	0.00	2,553.00	0.00	0.00	0.00
615	2013275074670	08/29/13 - 08/31/13	10/07/13	0.00	2,553.00	0.00	0.00	0.00
615	2214015001981	09/18/13 - 09/20/13	01/20/14	0.00	2,553.00	0.00	0.00	0.00
615	2014017078395	07/15/13 - 07/16/13	01/27/14	0.00	2,553.00	0.00	0.00	0.00
TOTAL				0.00	17,871.00	0.00	0.00	0.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
 Run Time: 00:13:51
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	371,504.09	ADJUSTMENTS	0.00
COVERED CHARGES	359,126.09	CONTRACTUAL ALLOW	266,203.76
NON-COVERD CHARGES	12,378.00	TOTAL MEDICAID LIAB	92,922.33
		LESS: COB	92,922.33
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 11

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	41		0	26,199.00		11,766.00
ROUTINE NURSERY	0		0	0.00		612.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	41		0	26,199.00		12,378.00
SPECIAL CARE SERVICES						
CCU	15		0	34,065.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	34,065.00		0.00
TOTAL ACCOMODATIONS	56		0	60,264.00		12,378.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	78,578.02	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	13,668.97	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	47,384.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,474.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,653.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	529.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	666.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	42,744.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	24,581.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,482.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,672.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,949.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,668.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,282.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,299.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,016.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	5,616.00	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	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	9,969.10	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,784.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,956.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,398.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	298,862.09	0.00
			TOTAL ACCOMODATIONS	60,264.00	12,378.00
			TOTAL CHARGES	359,126.09	12,378.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,199,435.40	ADJUSTMENTS	549,406.20
COVERED CHARGES	14,770,298.77	CONTRACTUAL ALLOW	12,137,029.58
NON-COVERD CHARGES	2,429,136.63	TOTAL MEDICAID LIAB	2,633,269.19
		LESS: COB	30,856.70
		LESS: COPAYMENT	5,198.70
		REIMBURSEMENT	2,597,213.79
		ALL OTHER	2,387,209.94
		FEE SCHEDULE-LAB	190,241.51
		INJECTABLE DRUGS	19,762.34

TOTAL NUMBER OF CLAIMS 6,566

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	432,842.68	27,855.45	OTHER LAB	95,278.00	968.00
MED/SURG SUPPLY	315,140.88	45,809.54	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	248.00	0.00
RADIOLOGY-DIAGNOSTIC	1,106,938.00	30,991.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,312,602.00	338,351.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,118.00	4,586.07	FEE SCHEDULE LAB	3,002,866.85	523,526.65
EKG/ECG	229,104.00	3,663.00	MRI SERVICES	165,236.00	33,218.00
IV THERAPY	172,076.00	61,451.00	PROFESSIONAL FEES	0.00	223.00
OPERATING ROOM	2,075,098.29	525,170.64	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	122,116.00	672.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	36,872.00	9,949.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	365,175.00	1,989.00	AMBULANCE	0.00	0.00
GI SERVICES	171,847.00	30,122.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,079,830.00	21,233.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	429,149.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	542,794.70	128,085.82
RADIOLOGY THERAPEUTIC	73,771.00	2,608.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	10,859.00	4,913.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	3,840.06	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,914.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	178,948.00	8,149.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	49,217.57	166,391.40
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	5,106.00
OTHER IMAGING SERVICE	762,539.00	181,532.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	77,134.00	31,059.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	264,540.00	52,660.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	260,563.00	170,192.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	148,687.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	273,707.80	9,908.00			
			TOTAL ANCILLARY	14,770,298.77	2,429,136.63
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,770,298.77	2,429,136.63

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
Run Time: 00:13:53
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013203024203	07/01/13 - 07/01/13	07/29/13	0.00	2,553.00	0.00	0.00	0.00
615	5913350002101	10/21/13 - 10/21/13	12/23/13	0.00	2,553.00	0.00	0.00	0.00
TOTAL				0.00	5,106.00	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
Run Time: 00:14:39
Page: 9

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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	241,112.65	ADJUSTMENTS	0.00
COVERED CHARGES	162,039.14	CONTRACTUAL ALLOW	97,700.53
NON-COVERD CHARGES	79,073.51	TOTAL MEDICAID LIAB	64,338.61
		LESS: COB	64,296.21
		LESS: COPAYMENT	42.40
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 84

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,334.61	1,135.00	OTHER LAB	2,829.00	0.00
MED/SURG SUPPLY	8,460.31	1,360.35	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,739.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,720.00	8,072.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	36,883.00	8,347.00
EKG/ECG	1,665.00	0.00	MRI SERVICES	2,745.00	0.00
IV THERAPY	4,125.00	586.00	PROFESSIONAL FEES	0.00	53.00
OPERATING ROOM	1,657.00	41,303.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	12,268.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	165.00	318.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,536.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	6,563.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	24,413.00	164.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,159.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,342.72	2,973.16
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	660.00	125.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,119.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,653.00	6,575.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,216.00	1,105.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,947.00	394.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,402.00	0.00			
			TOTAL ANCILLARY	162,039.14	79,073.51
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	162,039.14	79,073.51

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	823,060.61	ADJUSTMENTS	2,038.72
COVERED CHARGES	750,161.82	CONTRACTUAL ALLOW	706,654.65
NON-COVERD CHARGES	72,898.79	TOTAL MEDICAID LIAB	43,507.17
		LESS: COB	824.96
		LESS: COPAYMENT	1,389.02
		REIMBURSEMENT	41,293.19
		TOTAL NUMBER OF CLAIMS	763

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,805.46	160.00	OTHER LAB	4,285.00	0.00
MED/SURG SUPPLY	8,670.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	59,301.00	347.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	43,336.00	14,312.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	226,546.00	20,716.50
EKG/ECG	11,322.00	0.00	MRI SERVICES	3,853.00	3,033.00
IV THERAPY	12,815.00	7,530.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	319.00	2,243.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	250.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	273,613.00	328.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	40,154.36	9,216.29
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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,111.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	42,940.00	13,908.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,216.00	1,105.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	625.00	0.00			
			TOTAL ANCILLARY	750,161.82	72,898.79
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	750,161.82	72,898.79

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	325.34	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	182.00	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	3,113.00	228.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,882.00	82.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	81.86	60.54
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,070.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,654.20	370.54
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,654.20	370.54

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,601,153.48	ADJUSTMENTS	117,148.86
COVERED CHARGES	2,341,321.67	CONTRACTUAL ALLOW	2,016,434.08
NON-COVERD CHARGES	259,831.81	TOTAL MEDICAID LIAB	324,887.59
		LESS: COB	5,256.77
		LESS: COPAYMENT	300.00
		REIMBURSEMENT	319,330.82

TOTAL NUMBER OF CLAIMS 58

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55,535.42	6,498.04	OTHER LAB	1,121.00	0.00
MED/SURG SUPPLY	172,446.43	13,620.83	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,912.00	630.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,951.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	732.02	FEE SCHEDULE LAB	59,865.40	12,181.60
EKG/ECG	32,593.00	666.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,153.00	277.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,069,014.66	85,804.80	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,710.00	64.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	101,232.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,974.00	41.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	139,562.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	33,090.39	28,646.35
RADIOLOGY THERAPEUTIC	51,641.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	702.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	742.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	412,175.77	57,459.37
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,708.00	2,462.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,482.00	4,118.80			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,920.00	3,256.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	130,305.00	41,821.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,929.60	109.00			
			TOTAL ANCILLARY	2,341,321.67	259,831.81
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,341,321.67	259,831.81

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF 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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	41,797,756.89	ADJUSTMENTS	910,804.92
COVERED CHARGES	36,829,714.62	CONTRACTUAL ALLOW	30,058,000.01
NON-COVERD CHARGES	4,968,042.27	TOTAL MEDICAID LIAB	6,771,714.61
		LESS: COB	108,182.59
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,663,532.02

TOTAL NUMBER OF ADMISSIONS 880

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	4,267	48	4,745,603.56	4,439,945.40
ROUTINE NURSERY	354	14	428,916.00	8,808.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4,621	62	5,174,519.56	4,448,753.40
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1,102	0	2,600,131.00	0.00
NICU	134	0	340,896.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,236	0	2,941,027.00	0.00
TOTAL ACCOMODATIONS	5,857	62	8,115,546.56	4,448,753.40

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,608,447.10	150,887.00	OTHER LAB	239,198.99	1,448.94
MED/SURG SUPPLY	2,332,450.00	25,314.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,438,002.70	65,059.19	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	754,419.57	3,077.58	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,727,281.83	46,313.26	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	315,623.55	3,780.48	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	307,090.27	0.00	MRI SERVICES	307,942.84	5,925.08
IV THERAPY	2,252.88	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,092,277.50	14,612.12	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	387,311.81	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,682,386.65	4,141.38	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	439,364.34	6,891.47	AMBULANCE	0.00	0.00
GI SERVICES	164,254.95	9,000.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,136,090.71	685.74	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	412,182.80	3,457.15	DRUG-SPECIFIC/HOME IV	0.00	1,493.84
LABORATORY PATHOLOGIC	162,608.73	0.00	INJECTABLE DRUGS	4,034,772.91	57,983.40
RADIOLOGY THERAPEUTIC	0.00	757.66	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	147,123.12	549.17	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	147,192.91	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	172,052.38	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	15,651.12	1,012.39	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	18,668.00	0.00	IMPL DEV CHARGE PATIENTS	1,266,305.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	227,475.12	6,239.53			
BLOOD	891.00	0.00			
BLOOD STORAGE & PRO.	125,313.71	103,392.24			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	403,510.61	5,980.32			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	485,682.75	1,286.68			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	88,466.38	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	71,875.08	0.00			
			TOTAL ANCILLARY	28,714,168.06	519,288.87
			TOTAL ACCOMODATIONS	8,115,546.56	4,448,753.40
			TOTAL CHARGES	36,829,714.62	4,968,042.27

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	407,306.61	ADJUSTMENTS	0.00
COVERED CHARGES	405,161.97	CONTRACTUAL ALLOW	310,922.39
NON-COVERD CHARGES	2,144.64	TOTAL MEDICAID LIAB	94,239.58
		LESS: COB	94,239.58
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 12

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	15		0	16,815.00		520.32
ROUTINE NURSERY	6		0	5,832.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	21		0	22,647.00		520.32
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	17		0	40,644.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	40,644.00		0.00
TOTAL ACCOMODATIONS	38		0	63,291.00		520.32

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,731.37	0.00	OTHER LAB	2,140.22	0.00
MED/SURG SUPPLY	25,149.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	86,080.38	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,693.96	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,714.28	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,258.98	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,937.10	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	18,695.89	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	29,261.66	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	29,318.23	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,538.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,678.56	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,566.19	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,497.55	0.00	INJECTABLE DRUGS	34,162.01	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,098.32	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,549.12	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	11,319.92	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	141.26	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPTY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,654.68	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,330.80	1,624.32			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	13,146.98	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,389.84	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,816.42	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	341,870.97	1,624.32
			TOTAL ACCOMODATIONS	63,291.00	520.32
			TOTAL CHARGES	405,161.97	2,144.64

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
Run Time: 00:15:14
Page: 5

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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,762,755.50	ADJUSTMENTS	163,399.11
COVERED CHARGES	12,620,848.36	CONTRACTUAL ALLOW	10,720,651.35
NON-COVERD CHARGES	1,141,907.14	TOTAL MEDICAID LIAB	1,900,197.01
		LESS: COB	1,454.88
		LESS: COPAYMENT	3,102.00
		REIMBURSEMENT	1,895,640.13
		ALL OTHER	1,752,180.59
		FEE SCHEDULE-LAB	124,196.77
		INJECTABLE DRUGS	19,262.77

TOTAL NUMBER OF CLAIMS 3,685

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	307,110.30	706.00	OTHER LAB	243,186.57	4,431.52
MED/SURG SUPPLY	245,024.50	11,325.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	726,429.66	10,030.21	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,502,403.97	151,282.63	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	14,092.54	FEE SCHEDULE LAB	2,677,055.18	253,908.19
EKG/ECG	239,210.54	7,592.95	MRI SERVICES	229,532.02	33,867.37
IV THERAPY	429,618.42	69,041.06	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	584,500.76	57,391.03	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	80,534.75	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	71,227.12	3,852.93	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	195,310.55	0.00	AMBULANCE	0.00	0.00
GI SERVICES	14,300.00	3,700.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,070,717.00	89,247.23	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	405,860.70	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	245,781.95	59,974.49
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	527.56	6,908.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	511.97	10,592.32	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	14,149.90	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	154,421.96	11,308.34	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	33,168.25	10,007.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	500,919.79	88,134.91			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,210.68	2,436.48			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	366,149.14	45,751.59			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	93,822.80	81,377.48			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	42,869.98	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	146,442.24	100,796.72			
			TOTAL ANCILLARY	12,620,848.36	1,141,907.14
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,620,848.36	1,141,907.14

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	380,423.84	ADJUSTMENTS	0.00
COVERED CHARGES	308,645.39	CONTRACTUAL ALLOW	238,453.38
NON-COVERD CHARGES	71,778.45	TOTAL MEDICAID LIAB	70,192.01
		LESS: COB	70,135.01
		LESS: COPAYMENT	57.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 87

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,050.69	0.00	OTHER LAB	4,355.98	0.00
MED/SURG SUPPLY	1,272.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,368.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	35,321.57	47,683.33	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	61,895.89	9,641.05
EKG/ECG	6,418.11	587.42	MRI SERVICES	5,925.08	0.00
IV THERAPY	16,553.75	1,685.23	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,732.59	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,521.61	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	979.78	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,046.17	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	77,284.80	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,720.42	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,749.29	509.96
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	1,050.32	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,931.77	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,444.95	5,899.90			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,188.00	812.16			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	29,606.58	1,043.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,445.60	1,648.08			
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	2,831.76	1,218.00			
			TOTAL ANCILLARY	308,645.39	71,778.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	308,645.39	71,778.45

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
Run Time: 00:15:41
Page: 9

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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,273,064.47	ADJUSTMENTS	785.10
COVERED CHARGES	1,180,600.82	CONTRACTUAL ALLOW	1,152,933.52
NON-COVERD CHARGES	92,463.65	TOTAL MEDICAID LIAB	27,667.30
		LESS: COB	0.00
		LESS: COPAYMENT	951.01
		REIMBURSEMENT	26,716.29
		TOTAL NUMBER OF CLAIMS	495

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,832.39	25.07	OTHER LAB	5,729.38	0.00
MED/SURG SUPPLY	4,516.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	60,677.50	1,171.15	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	50,843.30	32,471.78	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	335,320.70	34,731.95
EKG/ECG	18,753.93	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	46,457.47	3,401.85	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,573.38	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,253.73	340.08	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,153.84	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	584,097.08	843.57	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,288.53	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,079.29	3,527.41
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	1,340.70	70.63	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	26,049.98	7,390.22			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	451.44	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	3,181.68	8,489.94			
			TOTAL ANCILLARY	1,180,600.82	92,463.65
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,180,600.82	92,463.65

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
 Run Time: 00:15:45
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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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 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	841.71	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	449.63	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,236.04	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,527.38	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,527.38	0.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,194,081.76	ADJUSTMENTS	28,907.59
COVERED CHARGES	1,141,551.02	CONTRACTUAL ALLOW	988,026.01
NON-COVERD CHARGES	52,530.74	TOTAL MEDICAID LIAB	153,525.01
		LESS: COB	10,196.58
		LESS: COPAYMENT	62.56
		REIMBURSEMENT	143,265.87
		TOTAL NUMBER OF CLAIMS	28

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 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	56,816.05	43.16	OTHER LAB	2,140.22	0.00
MED/SURG SUPPLY	114,973.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,523.42	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,812.00	12,669.62	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	443.66	FEE SCHEDULE LAB	49,358.92	7,373.28
EKG/ECG	3,981.41	2,306.17	MRI SERVICES	5,928.52	0.00
IV THERAPY	1,411.95	3,295.17	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	223,931.98	7,456.37	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,736.91	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	79,238.70	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	17,277.59	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	119,903.31	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,808.51	3,890.59
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,414.99	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	877.23	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	336,337.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,868.71	1,693.86			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	594.00	812.16			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	49,829.27	3,570.21			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,675.32	4,822.16			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,403.48	1,862.11			
			TOTAL ANCILLARY	1,141,551.02	52,530.74
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,141,551.02	52,530.74

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
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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	09/01/13	THROUGH	08/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,759,190.10	ADJUSTMENTS	11,690.12
COVERED CHARGES	1,699,134.10	CONTRACTUAL ALLOW	766,764.42
NON-COVERD CHARGES	60,056.00	TOTAL MEDICAID LIAB	932,369.68
		LESS: COB	11,946.76
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	920,422.92

TOTAL NUMBER OF ADMISSIONS 200

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	504		0	309,960.00		57,405.00
ROUTINE NURSERY	52		0	31,980.00		551.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	556		0	341,940.00		57,956.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	556		0	341,940.00		57,956.00

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	528,152.10	0.00	OTHER LAB	4,356.00	0.00
MED/SURG SUPPLY	235,833.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	221,268.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,545.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	38,398.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	16,744.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,050.00	0.00	MRI SERVICES	5,605.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	106,702.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	25,840.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	54,668.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,668.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,605.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	61.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	369.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,688.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,348.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,537.00	1,974.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,146.00	0.00			
AUDIOLOGY	5,525.00	0.00			
CARDIOLOGY	2,052.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,034.00	126.00			
			TOTAL ANCILLARY	1,357,194.10	2,100.00
			TOTAL ACCOMODATIONS	341,940.00	57,956.00
			TOTAL CHARGES	1,699,134.10	60,056.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,918.00	ADJUSTMENTS	0.00
COVERED CHARGES	13,657.00	CONTRACTUAL ALLOW	5,433.03
NON-COVERD CHARGES	1,261.00	TOTAL MEDICAID LIAB	8,223.97
		LESS: COB	8,223.97
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3		0	1,845.00		1,261.00
ROUTINE NURSERY	0		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	1,845.00		1,261.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	1,845.00		1,261.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,543.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	597.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,048.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	280.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,367.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,666.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	591.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	720.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	11,812.00	0.00
			TOTAL ACCOMODATIONS	1,845.00	1,261.00
			TOTAL CHARGES	13,657.00	1,261.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
Run Time: 00:15:59
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DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,887,150.00	ADJUSTMENTS	57.33
COVERED CHARGES	1,586,367.00	CONTRACTUAL ALLOW	1,202,751.23
NON-COVERD CHARGES	300,783.00	TOTAL MEDICAID LIAB	383,615.77
		LESS: COB	161.96
		LESS: COPAYMENT	1,158.00
		REIMBURSEMENT	382,295.81
		ALL OTHER	328,900.72
		FEE SCHEDULE-LAB	53,372.79
		INJECTABLE DRUGS	22.30
		TOTAL NUMBER OF CLAIMS	1,289

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	189,694.00	0.00	OTHER LAB	11,730.00	0.00
MED/SURG SUPPLY	177,075.00	1,131.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	626.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	103,672.00	922.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	72,328.00	4,159.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,952.00	12,995.00	FEE SCHEDULE LAB	519,301.00	122,019.00
EKG/ECG	10,780.00	0.00	MRI SERVICES	12,559.00	0.00
IV THERAPY	0.00	83,876.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	169,134.00	36,256.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	198.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,511.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,570.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	106,261.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	64,915.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	415.00	9,158.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	99,207.00	1,615.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,413.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,447.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	6,170.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,205.00	21,856.00			
			TOTAL ANCILLARY	1,586,367.00	300,783.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,586,367.00	300,783.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

Run Date: 07/15/2015
Run Time: 00:16:08
Page: 7

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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	49,772.00	ADJUSTMENTS	0.00
COVERED CHARGES	39,143.00	CONTRACTUAL ALLOW	7,498.87
NON-COVERD CHARGES	10,629.00	TOTAL MEDICAID LIAB	31,644.13
		LESS: COB	31,641.13
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 35

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,259.00	294.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,998.00	77.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	917.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,623.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	18,767.00	5,036.00
EKG/ECG	0.00	0.00	MRI SERVICES	2,876.00	0.00
IV THERAPY	0.00	3,288.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,108.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,800.00	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	1,031.00	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	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	192.00
OTHER IMAGING SERVICE	1,414.00	415.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,350.00	1,312.00			
			TOTAL ANCILLARY	39,143.00	10,629.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	39,143.00	10,629.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2315016000057	03/19/14 - 03/19/14	01/26/15	0.00	192.00	0.00	394.45	0.00
TOTAL				0.00	192.00	0.00	394.45	0.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
Run Time: 00:16:08
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DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	102,815.00	ADJUSTMENTS	0.00
COVERED CHARGES	96,462.00	CONTRACTUAL ALLOW	89,972.96
NON-COVERD CHARGES	6,353.00	TOTAL MEDICAID LIAB	6,489.04
		LESS: COB	0.00
		LESS: COPAYMENT	186.00
		REIMBURSEMENT	6,303.04
		TOTAL NUMBER OF CLAIMS	116

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,670.00	0.00	OTHER LAB	842.00	0.00
MED/SURG SUPPLY	816.00	71.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,056.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,744.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	28,719.00	3,029.00
EKG/ECG	280.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	2,313.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	465.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	42,126.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	744.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	940.00			
			TOTAL ANCILLARY	96,462.00	6,353.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	96,462.00	6,353.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,382.00	ADJUSTMENTS	0.00
COVERED CHARGES	8,334.00	CONTRACTUAL ALLOW	4,453.81
NON-COVERD CHARGES	48.00	TOTAL MEDICAID LIAB	3,880.19
		LESS: COB	3,880.19
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,425.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	744.00	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	2,248.00	48.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	469.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	448.00	0.00			
			TOTAL ANCILLARY	8,334.00	48.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,334.00	48.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	89,239.00	ADJUSTMENTS	0.00
COVERED CHARGES	89,215.00	CONTRACTUAL ALLOW	69,003.68
NON-COVERD CHARGES	24.00	TOTAL MEDICAID LIAB	20,211.32
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	20,196.32

TOTAL NUMBER OF CLAIMS 4

Report : CLM-0812-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,374.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	49,105.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	205.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,235.00	24.00
EKG/ECG	140.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	19,685.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	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	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,122.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	89,215.00	24.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	89,215.00	24.00

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO 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 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,971,506.92	ADJUSTMENTS	4,678,369.31
COVERED CHARGES	16,487,031.49	CONTRACTUAL ALLOW	9,473,101.16
NON-COVERD CHARGES	1,484,475.43	TOTAL MEDICAID LIAB	7,013,930.33
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,013,930.33

TOTAL NUMBER OF ADMISSIONS 111

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	4,149		0	5,418,225.00		64,358.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	4,149		0	5,418,225.00		64,358.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	74		0	195,318.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	74		0	195,318.00		0.00
TOTAL ACCOMODATIONS	4,223		0	5,613,543.00		64,358.00

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 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,021,349.55	4,179.00	OTHER LAB	195,162.00	0.00
MED/SURG SUPPLY	1,301,079.41	1,086,968.18	RECREATIONAL THERAPY	5,396.00	1,628.00
LABORATORY-GENERAL	473,118.00	21,970.00	EDUCATION & TRAINING	116,302.00	71,443.00
RADIOLOGY-DIAGNOSTIC	155,844.01	0.00	OTHER THERAPEUTIC SVC	636.00	19,090.00
CT SCAN	137,778.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,110,650.00	47,082.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	12,983.00	0.00	MRI SERVICES	45,831.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,538,179.22	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	922,314.00	17,073.00	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	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	173,630.30	784.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,088,036.00	46,400.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	517,646.00	28,322.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	4,141.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	42,747.25
OTHER IMAGING SERVICE	8,467.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,897.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,237.00	0.00			
AMBULATORY SURGERY	34,809.00	28,290.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,144.00	0.00			
			TOTAL ANCILLARY	10,873,488.49	1,420,117.43
			TOTAL ACCOMODATIONS	5,613,543.00	64,358.00
			TOTAL CHARGES	16,487,031.49	1,484,475.43

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 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013217032123	05/28/13 - 07/02/13	08/12/13	0.00	1,549.00	0.00	0.00	0.00
952	2013224028044	05/02/13 - 06/11/13	08/19/13	0.00	1,623.00	0.00	0.00	0.00
952	2213225006264	04/12/13 - 05/30/13	08/19/13	0.00	2,791.00	0.00	0.00	0.00
952	2213262004739	07/15/13 - 08/08/13	09/23/13	0.00	592.00	0.00	0.00	0.00
952	2213267005955	05/21/13 - 06/25/13	09/30/13	0.00	791.00	0.00	0.00	0.00
952	5213269000179	04/29/13 - 06/26/13	09/30/13	0.00	915.00	0.00	0.00	0.00
952	2013301039114	08/22/13 - 10/01/13	11/04/13	0.00	856.00	0.00	0.00	0.00
952	2013364030507	10/07/13 - 12/11/13	01/06/14	0.00	2,768.00	0.00	0.00	0.00
952	5214007032016	07/25/13 - 09/27/13	01/13/14	0.00	236.00	0.00	0.00	0.00
238	2214052013549	12/01/13 - 12/20/13	02/24/14	0.00	9,020.25	0.00	0.00	0.00
952	2214052013549	12/01/13 - 12/20/13	02/24/14	0.00	1,298.00	0.00	0.00	0.00
952	2014079096107	01/01/14 - 02/27/14	03/24/14	0.00	531.00	0.00	0.00	0.00
952	2014080081020	12/12/13 - 01/17/14	03/31/14	0.00	1,166.00	0.00	0.00	0.00
952	2014080081083	01/07/14 - 01/31/14	03/31/14	0.00	1,357.00	0.00	0.00	0.00
952	5214181000125	01/02/14 - 03/20/14	07/07/14	0.00	2,921.00	0.00	0.00	0.00
952	5214183000094	01/01/14 - 01/31/14	07/07/14	0.00	1,357.00	0.00	0.00	0.00
952	5214253000135	03/06/14 - 05/01/14	09/15/14	0.00	1,094.00	0.00	0.00	0.00
952	5214268000157	01/10/14 - 03/06/14	09/29/14	0.00	2,714.00	0.00	0.00	0.00
952	2014269068260	01/08/14 - 02/28/14	10/06/14	0.00	2,753.00	0.00	0.00	0.00
952	5214280000021	11/18/13 - 01/07/14	10/13/14	0.00	2,804.00	0.00	0.00	0.00
952	5214280000026	01/15/14 - 02/27/14	10/13/14	0.00	1,596.00	0.00	0.00	0.00
952	5215128000023	07/08/13 - 09/05/13	05/18/15	0.00	2,015.00	0.00	0.00	0.00
TOTAL				0.00	42,747.25	0.00	0.00	0.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

Run Date: 07/15/2015
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SHEPHERD CENTER
 2020 PEACHTREE RD NW
 ATLANTA,GA 30309-1426

PROVIDER NUMBER
 000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,125,776.60	ADJUSTMENTS	0.00
COVERED CHARGES	1,114,150.60	CONTRACTUAL ALLOW	790,851.44
NON-COVERD CHARGES	11,626.00	TOTAL MEDICAID LIAB	323,299.16
		LESS: COB	323,299.16
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	223		0	285,254.00		8,883.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	223		0	285,254.00		8,883.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1		0	2,638.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	2,638.00		0.00
TOTAL ACCOMODATIONS	224		0	287,892.00		8,883.00

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 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	221,416.60	0.00	OTHER LAB	4,855.00	0.00
MED/SURG SUPPLY	155,783.00	0.00	RECREATIONAL THERAPY	1,136.00	0.00
LABORATORY-GENERAL	13,940.00	0.00	EDUCATION & TRAINING	9,394.00	0.00
RADIOLOGY-DIAGNOSTIC	16,092.00	0.00	OTHER THERAPEUTIC SVC	0.00	370.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	71,815.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,410.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	207,662.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	390.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	91,853.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	29,089.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	72.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,301.00
OTHER IMAGING SERVICE	669.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	754.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	826,258.60	2,743.00
			TOTAL ACCOMODATIONS	287,892.00	8,883.00
			TOTAL CHARGES	1,114,150.60	11,626.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 04/01/13 THROUGH 03/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2214115016964	08/14/13 - 11/04/13	04/28/14	0.00	2,301.00	0.00	167,294.48	0.00
TOTAL				0.00	2,301.00	0.00	167,294.48	0.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/13 THROUGH 03/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,883,910.65	ADJUSTMENTS	99,143.10
COVERED CHARGES	2,799,530.60	CONTRACTUAL ALLOW	1,800,371.51
NON-COVERD CHARGES	1,084,380.05	TOTAL MEDICAID LIAB	999,159.09
		LESS: COB	4,120.61
		LESS: COPAYMENT	6,306.00
		REIMBURSEMENT	988,732.48
		ALL OTHER	556,792.49
		FEE SCHEDULE-LAB	23,963.10
		INJECTABLE DRUGS	407,976.89

TOTAL NUMBER OF CLAIMS 1,755

SHEPHERD CENTER
 2020 PEACHTREE RD NW
 ATLANTA,GA 30309-1426

PROVIDER NUMBER
 000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	84,099.40	0.00	OTHER LAB	34,154.00	2,442.00
MED/SURG SUPPLY	31,613.00	0.00	RECREATIONAL THERAPY	3,550.00	0.00
LABORATORY-GENERAL	0.00	454.00	EDUCATION & TRAINING	12,144.00	2,405.00
RADIOLOGY-DIAGNOSTIC	45,447.00	5,431.00	OTHER THERAPEUTIC SVC	0.00	832.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	223,149.00	134,352.00	FEE SCHEDULE LAB	211,779.00	6,302.00
EKG/ECG	846.00	1,692.00	MRI SERVICES	304,928.00	74,236.00
IV THERAPY	12,974.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,714.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	111.00	AMBULANCE	0.00	0.00
GI SERVICES	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	1,090,295.20	611,420.05
RADIOLOGY THERAPEUTIC	78,257.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	136,199.00	152,469.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	145,388.00	55,993.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	155.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	248,388.00	199.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,028.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	7,933.00	1,194.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	117,645.00	34,693.00			
			TOTAL ANCILLARY	2,799,530.60	1,084,380.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,799,530.60	1,084,380.05

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

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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	04/01/13	THROUGH	03/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/13	THROUGH	03/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/13	THROUGH	03/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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	04/01/13	THROUGH	03/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
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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	04/01/13	THROUGH	03/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
 Run Time: 00:16:48
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

NORTH FULTON REGIONAL HOSP
 3000 HOSPITAL BOULEVARD
 ROSWELL,GA 30076-4915

PROVIDER NUMBER 000275976A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	40,421,804.46	ADJUSTMENTS	1,639,689.23
COVERED CHARGES	39,783,749.46	CONTRACTUAL ALLOW	34,912,750.71
NON-COVERD CHARGES	638,055.00	TOTAL MEDICAID LIAB	4,870,998.75
		LESS: COB	52,580.70
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,818,418.05

TOTAL NUMBER OF ADMISSIONS 936

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,984		0	2,499,840.00		231,363.00
ROUTINE NURSERY	1,003		9	1,360,521.00		21,691.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,987		9	3,860,361.00		253,054.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	980		0	3,339,173.00		11,885.00
NICU	63		0	314,285.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,043		0	3,653,458.00		11,885.00
TOTAL ACCOMODATIONS	4,030		9	7,513,819.00		264,939.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

NORTH FULTON REGIONAL HOSP
 3000 HOSPITAL BOULEVARD
 ROSWELL,GA 30076-4915

PROVIDER NUMBER
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,683,954.50	21,080.50	OTHER LAB	103,519.40	0.00
MED/SURG SUPPLY	4,308,802.68	23,316.40	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,924,559.00	15,204.90	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	382,675.60	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,262,711.30	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	332,370.45	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	147,586.20	0.00	MRI SERVICES	255,662.00	0.00
IV THERAPY	44,219.50	3,304.70	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,262,479.50	21,288.70	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,160,295.40	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,523,224.60	1,789.30	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	522,495.90	0.00	AMBULANCE	0.00	0.00
GI SERVICES	306,794.10	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	744,109.30	3,944.20	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	576,868.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	248,828.20	0.00	INJECTABLE DRUGS	20,444.30	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	190,093.35	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	174,394.48	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	33,539.50	3,036.30	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	50,090.40	197.00	TRAUMA RESPONSE	0.00	23,004.90
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	799,783.10	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	182,723.70	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	256,949.10			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	110,925.00	0.00			
AUDIOLOGY	135,047.60	0.00			
CARDIOLOGY	643,012.20	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	25,528.80	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	113,191.90	0.00			
			TOTAL ANCILLARY	32,269,930.46	373,116.00
			TOTAL ACCOMODATIONS	7,513,819.00	264,939.00
			TOTAL CHARGES	39,783,749.46	638,055.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

NORTH FULTON REGIONAL HOSP
 3000 HOSPITAL BOULEVARD
 ROSWELL,GA 30076-4915

PROVIDER NUMBER
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	534,213.80	ADJUSTMENTS	0.00
COVERED CHARGES	527,694.80	CONTRACTUAL ALLOW	379,749.12
NON-COVERD CHARGES	6,519.00	TOTAL MEDICAID LIAB	147,945.68
		LESS: COB	147,945.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 12

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	15		0	18,900.00		945.00
ROUTINE NURSERY	21		2	55,825.00		1,686.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	36		2	74,725.00		2,631.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	10		0	48,350.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	10		0	48,350.00		0.00
TOTAL ACCOMODATIONS	46		2	123,075.00		2,631.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

NORTH FULTON REGIONAL HOSP
 3000 HOSPITAL BOULEVARD
 ROSWELL,GA 30076-4915

PROVIDER NUMBER
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	114,199.40	0.00	OTHER LAB	1,903.40	0.00
MED/SURG SUPPLY	84,111.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	60,065.20	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,402.10	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,189.70	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	659.10	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	28,340.30	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	32,371.20	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	29,249.90	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,827.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,040.60	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,532.30	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	4,192.20	0.00	INJECTABLE DRUGS	1,329.60	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	104.60	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,297.70	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	3,888.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	1,914.50	0.00			
CARDIOLOGY	2,889.20	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	404,619.80	3,888.00
			TOTAL ACCOMODATIONS	123,075.00	2,631.00
			TOTAL CHARGES	527,694.80	6,519.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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NORTH FULTON REGIONAL HOSP
3000 HOSPITAL BOULEVARD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,189,521.47	ADJUSTMENTS	252,116.36
COVERED CHARGES	8,308,130.72	CONTRACTUAL ALLOW	7,383,767.46
NON-COVERD CHARGES	881,390.75	TOTAL MEDICAID LIAB	924,363.26
		LESS: COB	3,294.22
		LESS: COPAYMENT	1,450.35
		REIMBURSEMENT	919,618.69
		ALL OTHER	852,782.28
		FEE SCHEDULE-LAB	60,010.68
		INJECTABLE DRUGS	6,825.73
		TOTAL NUMBER OF CLAIMS	1,993

NORTH FULTON REGIONAL HOSP
 3000 HOSPITAL BOULEVARD
 ROSWELL,GA 30076-4915

PROVIDER NUMBER
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	412,248.50	6,976.70	OTHER LAB	59,338.80	0.00
MED/SURG SUPPLY	549,478.64	3,719.10	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,729.35	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	407,373.20	1,763.40	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,005,061.30	157,116.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,749.67	FEE SCHEDULE LAB	1,528,460.60	305,041.56
EKG/ECG	133,965.00	1,977.30	MRI SERVICES	143,225.30	3,310.00
IV THERAPY	594,317.30	61,968.40	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	318,727.95	60,383.65	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	16,751.20	1,541.80	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	74,162.60	0.00	AMBULANCE	0.00	1,499.10
GI SERVICES	18,959.10	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,690,829.80	9,604.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	74,272.70	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	585,449.90	118,781.50
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	734.70	2,378.05	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	15,285.00	1,859.00	TRAUMA RESPONSE	0.00	8,417.80
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	10,476.00	15,117.60
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	251,464.30	38,160.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	42,708.20	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	40,324.70	37,879.60			
AMBULATORY SURGERY	152,799.63	32,274.47			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	74,193.20	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	107,523.10	8,141.20			
			TOTAL ANCILLARY	8,308,130.72	881,390.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,308,130.72	881,390.75

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

Run Date: 07/15/2015
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTH FULTON REGIONAL HOSP
3000 HOSPITAL BOULEVARD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	152,832.70	ADJUSTMENTS	0.00
COVERED CHARGES	142,250.00	CONTRACTUAL ALLOW	97,297.93
NON-COVERD CHARGES	10,582.70	TOTAL MEDICAID LIAB	44,952.07
		LESS: COB	44,943.07
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 21

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTH FULTON REGIONAL HOSP
 3000 HOSPITAL BOULEVARD
 ROSWELL,GA 30076-4915

PROVIDER NUMBER
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,813.80	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,914.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,965.90	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	32,668.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	18,274.90	479.70
EKG/ECG	3,328.50	0.00	MRI SERVICES	4,731.50	4,375.90
IV THERAPY	19,331.90	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,918.50	2,918.50	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	1,235.60	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	25,795.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,385.10	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	15,740.90	1,728.30
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	694.10	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,451.70	1,080.30			
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	0.00	0.00			
			TOTAL ANCILLARY	142,250.00	10,582.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	142,250.00	10,582.70

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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NORTH FULTON REGIONAL HOSP
3000 HOSPITAL BOULEVARD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	477,328.50	ADJUSTMENTS	370.57
COVERED CHARGES	456,648.50	CONTRACTUAL ALLOW	444,285.79
NON-COVERD CHARGES	20,680.00	TOTAL MEDICAID LIAB	12,362.71
		LESS: COB	0.00
		LESS: COPAYMENT	426.00
		REIMBURSEMENT	11,936.71
		TOTAL NUMBER OF CLAIMS	221

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

NORTH FULTON REGIONAL HOSP
 3000 HOSPITAL BOULEVARD
 ROSWELL,GA 30076-4915

PROVIDER NUMBER
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,966.10	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,005.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	23,741.80	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,741.80	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	97,638.60	8,105.10
EKG/ECG	8,700.30	692.10	MRI SERVICES	0.00	0.00
IV THERAPY	32,590.10	434.70	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	759.50	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	221,431.40	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	30,185.50	9,555.40
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	104.60	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	15,888.30	1,788.10			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	456,648.50	20,680.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	456,648.50	20,680.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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Page: 11

NORTH FULTON REGIONAL HOSP
3000 HOSPITAL BOULEVARD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	34,876.60	ADJUSTMENTS	0.00
COVERED CHARGES	31,046.20	CONTRACTUAL ALLOW	26,599.76
NON-COVERD CHARGES	3,830.40	TOTAL MEDICAID LIAB	4,446.44
		LESS: COB	4,434.44
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	6

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTH FULTON REGIONAL HOSP
 3000 HOSPITAL BOULEVARD
 ROSWELL,GA 30076-4915

PROVIDER NUMBER
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	417.20	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,227.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	515.70	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	6,191.80	15.90
EKG/ECG	692.10	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,580.70	2,608.20	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	7,976.90	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,444.70	1,206.30
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	31,046.20	3,830.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	31,046.20	3,830.40

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
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SUMMARY TYPE VII

Run Date: 07/15/2015
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTH FULTON REGIONAL HOSP
3000 HOSPITAL BOULEVARD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	337,599.70	ADJUSTMENTS	10,984.06
COVERED CHARGES	327,176.90	CONTRACTUAL ALLOW	283,565.89
NON-COVERD CHARGES	10,422.80	TOTAL MEDICAID LIAB	43,611.01
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	43,599.01
		TOTAL NUMBER OF CLAIMS	8

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTH FULTON REGIONAL HOSP
 3000 HOSPITAL BOULEVARD
 ROSWELL,GA 30076-4915

PROVIDER NUMBER
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,176.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	67,494.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	491.10	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	42,824.30	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	22,714.80	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,104.90	4,347.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	87,987.40	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	19,119.60	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,031.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,661.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,188.20	4,747.40
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	18,881.70	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,502.40	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	0.00	1,328.40			
			TOTAL ANCILLARY	327,176.90	10,422.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	327,176.90	10,422.80

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTH FULTON REGIONAL HOSP
3000 HOSPITAL BOULEVARD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
 Run Time: 00:17:19
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,015,554.24	ADJUSTMENTS	37,781.81
COVERED CHARGES	2,892,853.49	CONTRACTUAL ALLOW	2,071,023.41
NON-COVERD CHARGES	122,700.75	TOTAL MEDICAID LIAB	821,830.08
		LESS: COB	3,229.30
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	818,600.78

TOTAL NUMBER OF ADMISSIONS 98

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	328		0	287,656.00		79,337.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	328		0	287,656.00		79,337.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	46		0	103,904.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	46		0	103,904.00		0.00
TOTAL ACCOMODATIONS	374		0	391,560.00		79,337.00

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
 Run Time: 00:17:19
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	182,440.75	0.00	OTHER LAB	15,831.00	0.00
MED/SURG SUPPLY	104,903.28	123.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	507,381.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	87,977.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	126,239.00	35,976.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	41,202.42	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	21,621.25	0.00	MRI SERVICES	49,177.25	0.00
IV THERAPY	16,990.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	224,922.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	101,138.50	646.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	89,419.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	9,895.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	122,890.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	38,526.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	4,571.00
LABORATORY PATHOLOGIC	1,766.75	0.00	INJECTABLE DRUGS	416,610.75	28.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	23,542.54	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,391.25	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	10,113.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,029.75	49.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	176,546.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	19,493.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	13,164.25	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	17,462.00	1,969.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	78,743.75	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	874.00	0.00			
			TOTAL ANCILLARY	2,501,293.49	43,363.75
			TOTAL ACCOMODATIONS	391,560.00	79,337.00
			TOTAL CHARGES	2,892,853.49	122,700.75

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
Run Time: 00:17:22
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COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,224,440.69	ADJUSTMENTS	45,476.03
COVERED CHARGES	3,865,774.50	CONTRACTUAL ALLOW	3,191,706.57
NON-COVERD CHARGES	358,666.19	TOTAL MEDICAID LIAB	674,067.93
		LESS: COB	1,488.99
		LESS: COPAYMENT	628.03
		REIMBURSEMENT	671,950.91
		ALL OTHER	620,179.91
		FEE SCHEDULE-LAB	46,309.25
		INJECTABLE DRUGS	5,461.75
		TOTAL NUMBER OF CLAIMS	1,571

COLISEUM NORTHSIDE HOSPITAL
 400 CHARTER BLVD
 MACON,GA 31210-4831

PROVIDER NUMBER
 000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	87,854.00	167.00	OTHER LAB	88,681.00	0.00
MED/SURG SUPPLY	27,543.25	318.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	498.25	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	421,420.75	3,272.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	609,565.50	118,861.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	30,733.25	1,214.25	FEE SCHEDULE LAB	846,277.89	89,017.75
EKG/ECG	54,362.50	1,771.25	MRI SERVICES	14,647.75	10,020.00
IV THERAPY	139,633.00	11,260.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	113,669.20	37,225.69	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	15,846.25	4,105.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	55,690.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	50,656.00	4,854.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,071,477.50	28,370.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	38,034.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	75,731.79	20,512.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,395.50	543.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,123.00	2,373.25	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,062.75	1,201.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	12,539.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	71,531.50	12,748.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,775.75	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	11,055.75	3,150.25			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,030.00	7,181.25			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,436.37	0.00			
			TOTAL ANCILLARY	3,865,774.50	358,666.19
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,865,774.50	358,666.19

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
Run Time: 00:17:33
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	114,991.25	ADJUSTMENTS	0.00
COVERED CHARGES	97,549.50	CONTRACTUAL ALLOW	61,625.68
NON-COVERD CHARGES	17,441.75	TOTAL MEDICAID LIAB	35,923.82
		LESS: COB	35,911.82
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 30

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,703.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,598.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,141.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,243.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	31,961.00	6,446.75
EKG/ECG	2,850.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,220.75	394.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	9,311.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	376.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,340.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,559.25	883.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,878.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	511.75	405.75
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	9,765.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,399.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	97,549.50	17,441.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	97,549.50	17,441.75

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	532,734.03	ADJUSTMENTS	535.40
COVERED CHARGES	506,825.50	CONTRACTUAL ALLOW	484,729.20
NON-COVERD CHARGES	25,908.53	TOTAL MEDICAID LIAB	22,096.30
		LESS: COB	0.00
		LESS: COPAYMENT	744.00
		REIMBURSEMENT	21,352.30
		TOTAL NUMBER OF CLAIMS	395

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,442.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	707.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	498.25	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	63,700.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,507.75	15,496.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	94,802.00	2,459.25
EKG/ECG	3,542.50	356.25	MRI SERVICES	0.00	0.00
IV THERAPY	14,700.50	825.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	2,845.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	481.00	226.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,122.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	278,430.00	663.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,878.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,344.00	1,606.78
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,782.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,384.25	930.50			
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	506,825.50	25,908.53
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	506,825.50	25,908.53

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,519.00	ADJUSTMENTS	0.00
COVERED CHARGES	9,390.25	CONTRACTUAL ALLOW	6,098.23
NON-COVERD CHARGES	128.75	TOTAL MEDICAID LIAB	3,292.02
		LESS: COB	3,280.02
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	327.00	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	2,850.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,183.75	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	124.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,791.50	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	113.50	128.75
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	9,390.25	128.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,390.25	128.75

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	255,031.75	ADJUSTMENTS	5,820.41
COVERED CHARGES	254,061.75	CONTRACTUAL ALLOW	215,018.13
NON-COVERD CHARGES	970.00	TOTAL MEDICAID LIAB	39,043.62
		LESS: COB	0.00
		LESS: COPAYMENT	25.30
		REIMBURSEMENT	39,018.32

TOTAL NUMBER OF CLAIMS 7

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,912.00	0.00	OTHER LAB	1,193.50	0.00
MED/SURG SUPPLY	9,645.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,091.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,375.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,857.25	297.75
EKG/ECG	702.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	316.50	481.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	125,231.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	49,651.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,223.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,788.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,816.50	190.50
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	99.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	24,637.25	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.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	520.00	0.00			
			TOTAL ANCILLARY	254,061.75	970.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	254,061.75	970.00

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE I
 INPATIENT PAID CLAIMS

Run Date: 07/15/2015
 Run Time: 00:42:28
 Page: 1

NORTHSIDE MEDICAL CENTER
 100 FRIST CT
 COLUMBUS,GA 31909-3578

PROVIDER NUMBER
 000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	466,310.70	ADJUSTMENTS	0.00
COVERED CHARGES	466,310.70	CONTRACTUAL ALLOW	322,571.34
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	143,739.36
		LESS: COB	441.32
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	143,298.04

TOTAL NUMBER OF ADMISSIONS 9

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	30		0	27,000.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	30		0	27,000.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1		0	1,680.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1		0	1,680.00		0.00
TOTAL ACCOMODATIONS	31		0	28,680.00		0.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,938.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	37,497.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,586.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,833.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,427.03	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	612.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	117,162.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	476.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	22,254.00	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	16,446.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	348.00	0.00	INJECTABLE DRUGS	27,190.64	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,852.03	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	126.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	181,978.75	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	902.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	437,630.70	0.00
			TOTAL ACCOMODATIONS	28,680.00	0.00
			TOTAL CHARGES	466,310.70	0.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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NORTHSIDE MEDICAL CENTER
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	144,679.64	ADJUSTMENTS	461.49
COVERED CHARGES	133,261.09	CONTRACTUAL ALLOW	105,847.39
NON-COVERD CHARGES	11,418.55	TOTAL MEDICAID LIAB	27,413.70
		LESS: COB	0.00
		LESS: COPAYMENT	87.00
		REIMBURSEMENT	27,326.70
		ALL OTHER	26,735.36
		FEE SCHEDULE-LAB	451.04
		INJECTABLE DRUGS	140.30

TOTAL NUMBER OF CLAIMS 29

Report : CLM-0804-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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NORTHSIDE MEDICAL CENTER
 100 FRIST CT
 COLUMBUS,GA 31909-3578

PROVIDER NUMBER
 000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,642.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,130.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,345.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	307.00	1,099.13	FEE SCHEDULE LAB	5,616.00	174.75
EKG/ECG	1,020.00	204.00	MRI SERVICES	15,374.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	50,717.84	9,681.66	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	15,654.00	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	11,502.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,082.50	61.93
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,143.00	197.08	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	264.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	9,658.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,805.50	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	133,261.09	11,418.55
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	133,261.09	11,418.55

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	921.50	ADJUSTMENTS	0.00
COVERED CHARGES	901.50	CONTRACTUAL ALLOW	544.66
NON-COVERD CHARGES	20.00	TOTAL MEDICAID LIAB	356.84
		LESS: COB	353.84
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 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	315.50	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	382.00	20.00
EKG/ECG	204.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	901.50	20.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	901.50	20.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
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SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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NORTHSIDE MEDICAL CENTER
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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NORTHSIDE MEDICAL CENTER
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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WESLEY WOODS GERIATRIC HOSP
 1821 CLIFTON RD NE
 ATLANTA,GA 30329-4021

PROVIDER NUMBER 000339831A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,514,321.48	ADJUSTMENTS	54,079.65
COVERED CHARGES	2,649,058.48	CONTRACTUAL ALLOW	751,196.91
NON-COVERD CHARGES	865,263.00	TOTAL MEDICAID LIAB	1,897,861.57
		LESS: COB	10,080.42
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,887,781.15

TOTAL NUMBER OF ADMISSIONS 165

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,046		12	1,317,960.00		856,815.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,046		12	1,317,960.00		856,815.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	1,046		12	1,317,960.00		856,815.00

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

WESLEY WOODS GERIATRIC HOSP
 1821 CLIFTON RD NE
 ATLANTA,GA 30329-4021

PROVIDER NUMBER
 000339831A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	66,807.24	0.00	OTHER LAB	6,680.00	0.00
MED/SURG SUPPLY	72,968.90	2,974.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	352,053.00	2,137.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,032.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	39,565.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	52,420.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	18,064.00	0.00	MRI SERVICES	8,909.00	0.00
IV THERAPY	586.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,412.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	235,791.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,473.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	15,774.00	0.00	INJECTABLE DRUGS	263,628.34	495.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	74,674.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	24,114.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	7,845.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	27,630.00	0.00	IMPL DEV CHARGE PATIENTS	1,393.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,841.00
OTHER IMAGING SERVICE	2,030.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,451.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,162.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	636.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,331,098.48	8,448.00
			TOTAL ACCOMODATIONS	1,317,960.00	856,815.00
			TOTAL CHARGES	2,649,058.48	865,263.00

Report : CLM-0800-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

Run Date: 07/15/2015
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WESLEY WOODS GERIATRIC HOSP
1821 CLIFTON RD NE
ATLANTA,GA 30329-4021

PROVIDER NUMBER
000339831A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014226026593	05/02/14 - 07/01/14	08/18/14	0.00	2,841.00	0.00	0.00	0.00
TOTAL				0.00	2,841.00	0.00	0.00	0.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

WESLEY WOODS GERIATRIC HOSP
1821 CLIFTON RD NE
ATLANTA,GA 30329-4021

PROVIDER NUMBER
000339831A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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WESLEY WOODS GERIATRIC HOSP
1821 CLIFTON RD NE
ATLANTA,GA 30329-4021

PROVIDER NUMBER
000339831A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	664,102.89	ADJUSTMENTS	23,084.01
COVERED CHARGES	624,840.37	CONTRACTUAL ALLOW	373,435.39
NON-COVERD CHARGES	39,262.52	TOTAL MEDICAID LIAB	251,404.98
		LESS: COB	1,485.64
		LESS: COPAYMENT	894.00
		REIMBURSEMENT	249,025.34
		ALL OTHER	244,934.70
		FEE SCHEDULE-LAB	1,010.04
		INJECTABLE DRUGS	3,080.60

TOTAL NUMBER OF CLAIMS 324

Report : CLM-0804-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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WESLEY WOODS GERIATRIC HOSP
 1821 CLIFTON RD NE
 ATLANTA,GA 30329-4021

PROVIDER NUMBER
 000339831A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,492.09	1,221.07	OTHER LAB	790.00	0.00
MED/SURG SUPPLY	5,677.00	8,242.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,147.00	2,936.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	5,026.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,036.00	540.00
EKG/ECG	393.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	879.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	87,674.00	8,329.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,783.28	12,020.45
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	69.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	11,876.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	116,046.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	338,926.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	624,840.37	39,262.52
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	624,840.37	39,262.52

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WESLEY WOODS GERIATRIC HOSP
1821 CLIFTON RD NE
ATLANTA,GA 30329-4021

PROVIDER NUMBER
000339831A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,012.54	ADJUSTMENTS	0.00
COVERED CHARGES	24,697.54	CONTRACTUAL ALLOW	10,070.89
NON-COVERD CHARGES	315.00	TOTAL MEDICAID LIAB	14,626.65
		LESS: COB	14,593.65
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 11

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WESLEY WOODS GERIATRIC HOSP
 1821 CLIFTON RD NE
 ATLANTA,GA 30329-4021

PROVIDER NUMBER
 000339831A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	224.00	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	800.54	315.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	4,605.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	19,068.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	24,697.54	315.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	24,697.54	315.00

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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WESLEY WOODS GERIATRIC HOSP
1821 CLIFTON RD NE
ATLANTA,GA 30329-4021

PROVIDER NUMBER
000339831A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/13	THROUGH	08/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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WESLEY WOODS GERIATRIC HOSP
1821 CLIFTON RD NE
ATLANTA,GA 30329-4021

PROVIDER NUMBER
000339831A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/13	THROUGH	08/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WESLEY WOODS GERIATRIC HOSP
1821 CLIFTON RD NE
ATLANTA,GA 30329-4021

PROVIDER NUMBER
000339831A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/13	THROUGH	08/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
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SUMMARY TYPE VIII

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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WESLEY WOODS GERIATRIC HOSP
1821 CLIFTON RD NE
ATLANTA,GA 30329-4021

PROVIDER NUMBER
000339831A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/13	THROUGH	08/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 04/26/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	53,451.55	ADJUSTMENTS	0.00
COVERED CHARGES	27,379.55	CONTRACTUAL ALLOW	-8,655.97
NON-COVERD CHARGES	26,072.00	TOTAL MEDICAID LIAB	36,035.52
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	36,035.52

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	0		29	0.00		26,072.00
ROUTINE NURSERY	0		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		29	0.00		26,072.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	0		29	0.00		26,072.00

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 04/26/13 THROUGH 03/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,060.67	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,549.88	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,965.00	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	7,577.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,227.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	27,379.55	0.00
			TOTAL ACCOMODATIONS	0.00	26,072.00
			TOTAL CHARGES	27,379.55	26,072.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
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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 04/26/13 THROUGH 03/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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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 04/26/13 THROUGH 03/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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	04/26/13	THROUGH	03/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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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 04/26/13 THROUGH 03/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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	04/26/13	THROUGH	03/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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	04/26/13	THROUGH	03/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
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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	04/26/13	THROUGH	03/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

KINDRED HOSPITAL ATLANTA
 705 JUNIPER ST NE
 ATLANTA,GA 30308-1307

PROVIDER NUMBER 000472513A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,405,069.33	ADJUSTMENTS	638,550.96
COVERED CHARGES	23,222,805.03	CONTRACTUAL ALLOW	17,187,770.71
NON-COVERD CHARGES	4,182,264.30	TOTAL MEDICAID LIAB	6,035,034.32
		LESS: COB	43,160.61
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,991,873.71

TOTAL NUMBER OF ADMISSIONS 135

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,309		437	3,513,154.00		3,321,982.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,309		437	3,513,154.00		3,321,982.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	891		0	2,042,427.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	891		0	2,042,427.00		0.00
TOTAL ACCOMODATIONS	4,200		437	5,555,581.00		3,321,982.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

KINDRED HOSPITAL ATLANTA
 705 JUNIPER ST NE
 ATLANTA,GA 30308-1307

PROVIDER NUMBER
 000472513A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,670,269.01	251.80	OTHER LAB	22,054.00	0.00
MED/SURG SUPPLY	2,382,097.00	2,680.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,079,871.00	54,463.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	295,277.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	78,139.00	8,041.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	226,115.25	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	38,844.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	615,884.00	3,619.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,042,887.00	733,679.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	126,641.00	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	72,506.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	190,782.21	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	258,456.56	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	379,614.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	19,672.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	90,412.00	55,916.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	25,161.00	1,632.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	17,724.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	34,818.00	0.00			
			TOTAL ANCILLARY	17,667,224.03	860,282.30
			TOTAL ACCOMODATIONS	5,555,581.00	3,321,982.00
			TOTAL CHARGES	23,222,805.03	4,182,264.30

Report : CLM-0802-0
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Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

KINDRED HOSPITAL ATLANTA
705 JUNIPER ST NE
ATLANTA,GA 30308-1307

PROVIDER NUMBER
000472513A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/13	THROUGH	08/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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KINDRED HOSPITAL ATLANTA
705 JUNIPER ST NE
ATLANTA,GA 30308-1307

PROVIDER NUMBER
000472513A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

KINDRED HOSPITAL ATLANTA
705 JUNIPER ST NE
ATLANTA,GA 30308-1307

PROVIDER NUMBER
000472513A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/13	THROUGH	08/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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KINDRED HOSPITAL ATLANTA
705 JUNIPER ST NE
ATLANTA,GA 30308-1307

PROVIDER NUMBER
000472513A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/13	THROUGH	08/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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KINDRED HOSPITAL ATLANTA
705 JUNIPER ST NE
ATLANTA,GA 30308-1307

PROVIDER NUMBER
000472513A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/13	THROUGH	08/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

KINDRED HOSPITAL ATLANTA
705 JUNIPER ST NE
ATLANTA,GA 30308-1307

PROVIDER NUMBER
000472513A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/13	THROUGH	08/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

KINDRED HOSPITAL ATLANTA
705 JUNIPER ST NE
ATLANTA,GA 30308-1307

PROVIDER NUMBER
000472513A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/13	THROUGH	08/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,357,247.85	ADJUSTMENTS	210,492.13
COVERED CHARGES	9,114,485.15	CONTRACTUAL ALLOW	6,548,475.37
NON-COVERD CHARGES	242,762.70	TOTAL MEDICAID LIAB	2,566,009.78
		LESS: COB	9,371.12
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,556,638.66

TOTAL NUMBER OF ADMISSIONS 390

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,037		2	1,110,555.00		209,309.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,037		2	1,110,555.00		209,309.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	1,037		2	1,110,555.00		209,309.00

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	732,627.50	0.00	OTHER LAB	14,806.50	0.00
MED/SURG SUPPLY	111,001.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	707,307.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	174,453.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,486.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,143.25	0.00	MRI SERVICES	7,630.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	674.70
OPERATING ROOM	85,044.00	550.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,928,044.00	14,547.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,076,889.25	1,431.75	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	27.50	0.00
RADIOLOGY THERAPEUTIC	198.50	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	1,722.25
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	12,794.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	48,241.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	61,964.00	1,733.25			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	28,065.30	0.00			
			TOTAL ANCILLARY	8,003,930.15	33,453.70
			TOTAL ACCOMODATIONS	1,110,555.00	209,309.00
			TOTAL CHARGES	9,114,485.15	242,762.70

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 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	42,695.75	ADJUSTMENTS	0.00
COVERED CHARGES	42,092.75	CONTRACTUAL ALLOW	2,640.29
NON-COVERD CHARGES	603.00	TOTAL MEDICAID LIAB	39,452.46
		LESS: COB	39,452.46
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3		0	3,219.00		603.00
ROUTINE NURSERY	0		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	3,219.00		603.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	3,219.00		603.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,068.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,919.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	446.75	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	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	30,367.50	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	2,341.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,661.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	69.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	38,873.75	0.00
			TOTAL ACCOMODATIONS	3,219.00	603.00
			TOTAL CHARGES	42,092.75	603.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,426,811.44	ADJUSTMENTS	699,943.02
COVERED CHARGES	18,813,742.00	CONTRACTUAL ALLOW	13,843,560.98
NON-COVERD CHARGES	613,069.44	TOTAL MEDICAID LIAB	4,970,181.02
		LESS: COB	2,546.37
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	4,967,622.65
		ALL OTHER	4,456,908.86
		FEE SCHEDULE-LAB	215,231.08
		INJECTABLE DRUGS	295,482.71
		TOTAL NUMBER OF CLAIMS	12,005

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	300,417.00	144.00	OTHER LAB	385,817.50	11,817.50
MED/SURG SUPPLY	387,869.05	520.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	224.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	581,264.00	1,206.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	50,531.75	2,280.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,891,817.50	250,441.55
EKG/ECG	46,127.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	768.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	168,548.00	505.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,698,361.25	195,290.50	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	7,037,832.40	17,094.25	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	924,060.50	128,491.84
RADIOLOGY THERAPEUTIC	27,315.75	198.50	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	1,246.25
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,450,966.15	464.10	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	116,228.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	617,623.50	1,599.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	3,276.50	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	124,917.90	1,545.70			
			TOTAL ANCILLARY	18,813,742.00	613,069.44
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,813,742.00	613,069.44

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	55,609.90	ADJUSTMENTS	0.00
COVERED CHARGES	51,404.40	CONTRACTUAL ALLOW	36,912.53
NON-COVERD CHARGES	4,205.50	TOTAL MEDICAID LIAB	14,491.87
		LESS: COB	14,491.87
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 16

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	649.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	561.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,340.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,722.25	724.50
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	6,522.75	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	19,933.50	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	332.25	14.50
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	3,694.25	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.	3,476.00	3,466.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,172.60	0.00			
			TOTAL ANCILLARY	51,404.40	4,205.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	51,404.40	4,205.50

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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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 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,998,832.58	ADJUSTMENTS	2,237.60
COVERED CHARGES	1,983,099.58	CONTRACTUAL ALLOW	1,892,588.63
NON-COVERD CHARGES	15,733.00	TOTAL MEDICAID LIAB	90,510.95
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	90,510.95
		TOTAL NUMBER OF CLAIMS	1,621

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 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,561.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	31,369.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	44,633.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,280.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	169,811.75	14,463.25
EKG/ECG	2,414.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,778.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	27,217.75	620.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,660,636.13	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,547.75	328.25
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	182.25
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	838.75	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	3,732.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,279.20	0.00			
			TOTAL ANCILLARY	1,983,099.58	15,594.50
			TOTAL ACCOMODATIONS	0.00	138.50
			TOTAL CHARGES	1,983,099.58	15,733.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
Run Time: 00:43:46
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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	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
Run Time: 00:43:51
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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	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE I
 INPATIENT PAID CLAIMS

Run Date: 07/15/2015
 Run Time: 00:44:00
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MORGAN MEMORIAL HOSPITAL
 1077 S MAIN ST
 MADISON,GA 30650-2073

PROVIDER NUMBER 000694229A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	137,824.73	ADJUSTMENTS	15,268.23
COVERED CHARGES	136,599.73	CONTRACTUAL ALLOW	49,385.89
NON-COVERD CHARGES	1,225.00	TOTAL MEDICAID LIAB	87,213.84
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	87,213.84

TOTAL NUMBER OF ADMISSIONS 17

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	28		0	14,868.00		1,225.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	28		0	14,868.00		1,225.00
SPECIAL CARE SERVICES						
CCU	19		0	12,540.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	19		0	12,540.00		0.00
TOTAL ACCOMODATIONS	47		0	27,408.00		1,225.00

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

MORGAN MEMORIAL HOSPITAL
 1077 S MAIN ST
 MADISON,GA 30650-2073

PROVIDER NUMBER
 000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,951.60	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	13,397.56	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	26,917.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,283.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,307.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,944.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,130.77	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	4,551.80	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,295.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,108.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	306.00	0.00			
			TOTAL ANCILLARY	109,191.73	0.00
			TOTAL ACCOMODATIONS	27,408.00	1,225.00
			TOTAL CHARGES	136,599.73	1,225.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MORGAN MEMORIAL HOSPITAL
1077 S MAIN ST
MADISON,GA 30650-2073

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
Run Time: 00:44:00
Page: 4

MORGAN MEMORIAL HOSPITAL
1077 S MAIN ST
MADISON,GA 30650-2073

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	904,166.28	ADJUSTMENTS	170,119.42
COVERED CHARGES	843,589.80	CONTRACTUAL ALLOW	488,218.47
NON-COVERD CHARGES	60,576.48	TOTAL MEDICAID LIAB	355,371.33
		LESS: COB	1,158.86
		LESS: COPAYMENT	579.00
		REIMBURSEMENT	353,633.47
		ALL OTHER	328,587.08
		FEE SCHEDULE-LAB	22,756.28
		INJECTABLE DRUGS	2,290.11

TOTAL NUMBER OF CLAIMS 797

Report : CLM-0804-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
 Run Time: 00:44:00
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MORGAN MEMORIAL HOSPITAL
 1077 S MAIN ST
 MADISON,GA 30650-2073

PROVIDER NUMBER
 000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36,573.73	3,955.31	OTHER LAB	13,430.32	0.00
MED/SURG SUPPLY	12,495.08	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	98.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	55,617.00	162.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	166,584.00	4,407.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,034.00	320.00	FEE SCHEDULE LAB	191,029.25	38,893.50
EKG/ECG	9,600.00	128.00	MRI SERVICES	6,000.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	144.00
OPERATING ROOM	14,612.40	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,920.76	1,073.27	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,645.20	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	272,199.48	2,713.04	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,618.58	2,110.36
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,177.00	751.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	502.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,553.00	249.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,496.00	566.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,054.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,448.00	5,006.00			
			TOTAL ANCILLARY	843,589.80	60,576.48
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	843,589.80	60,576.48

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MORGAN MEMORIAL HOSPITAL
1077 S MAIN ST
MADISON,GA 30650-2073

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,826.11	ADJUSTMENTS	0.00
COVERED CHARGES	6,720.91	CONTRACTUAL ALLOW	1,346.99
NON-COVERD CHARGES	2,105.20	TOTAL MEDICAID LIAB	5,373.92
		LESS: COB	5,373.92
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 10

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MORGAN MEMORIAL HOSPITAL
 1077 S MAIN ST
 MADISON,GA 30650-2073

PROVIDER NUMBER
 000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	203.20	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	35.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	914.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,607.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,668.75	295.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,067.16	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	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	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,720.91	2,105.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,720.91	2,105.20

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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MORGAN MEMORIAL HOSPITAL
1077 S MAIN ST
MADISON,GA 30650-2073

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	40,814.31	ADJUSTMENTS	1,002.00
COVERED CHARGES	36,992.92	CONTRACTUAL ALLOW	32,892.92
NON-COVERD CHARGES	3,821.39	TOTAL MEDICAID LIAB	4,100.00
		LESS: COB	0.00
		LESS: COPAYMENT	132.00
		REIMBURSEMENT	3,968.00
		TOTAL NUMBER OF CLAIMS	82

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

MORGAN MEMORIAL HOSPITAL
 1077 S MAIN ST
 MADISON,GA 30650-2073

PROVIDER NUMBER
 000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	622.88	568.32	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	304.45	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,138.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,607.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,059.00	563.00
EKG/ECG	256.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	239.60	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	24,823.24	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	573.75	439.07
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	976.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	644.00			
			TOTAL ANCILLARY	36,992.92	3,821.39
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	36,992.92	3,821.39

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MORGAN MEMORIAL HOSPITAL
1077 S MAIN ST
MADISON,GA 30650-2073

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,400.07	ADJUSTMENTS	0.00
COVERED CHARGES	983.07	CONTRACTUAL ALLOW	515.43
NON-COVERD CHARGES	1,417.00	TOTAL MEDICAID LIAB	467.64
		LESS: COB	467.64
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MORGAN MEMORIAL HOSPITAL
 1077 S MAIN ST
 MADISON,GA 30650-2073

PROVIDER NUMBER
 000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 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	33.67	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,400.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	290.00	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	635.40	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	24.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	983.07	1,417.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	983.07	1,417.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MORGAN MEMORIAL HOSPITAL
1077 S MAIN ST
MADISON,GA 30650-2073

PROVIDER NUMBER
000694229A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MORGAN MEMORIAL HOSPITAL
1077 S MAIN ST
MADISON,GA 30650-2073

PROVIDER NUMBER
000694229A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,834,422.21	ADJUSTMENTS	1,168,965.47
COVERED CHARGES	20,603,344.57	CONTRACTUAL ALLOW	15,050,585.16
NON-COVERD CHARGES	231,077.64	TOTAL MEDICAID LIAB	5,552,759.41
		LESS: COB	52,731.56
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,500,027.85

TOTAL NUMBER OF ADMISSIONS 577

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,753		0	1,612,760.00		96,792.00
ROUTINE NURSERY	618		0	685,319.00		182.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,371		0	2,298,079.00		96,974.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	633		0	1,592,314.00		0.00
NICU	402		0	922,170.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,035		0	2,514,484.00		0.00
TOTAL ACCOMODATIONS	3,406		0	4,812,563.00		96,974.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,520,386.62	640.00	OTHER LAB	182,477.00	0.00
MED/SURG SUPPLY	478,192.02	9,912.64	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,446,948.72	25,051.00	EDUCATION & TRAINING	3,163.00	0.00
RADIOLOGY-DIAGNOSTIC	553,375.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,217,702.00	8,481.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	180,962.04	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	132,039.00	0.00	MRI SERVICES	232,254.00	0.00
IV THERAPY	105,905.00	5,738.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,277,536.00	17,665.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	476,526.00	2,142.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,523,230.00	9,685.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	147,357.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	168,021.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	677,477.00	15,508.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	265,641.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	195,397.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	102,115.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	105,731.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	22,802.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	345,708.00	3,564.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	30,294.00	1,462.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	178,170.57	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	338,063.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	428,166.00	24,949.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	61,460.00	9,306.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	329,716.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	10,037.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	53,929.60	0.00			
			TOTAL ANCILLARY	15,790,781.57	134,103.64
			TOTAL ACCOMODATIONS	4,812,563.00	96,974.00
			TOTAL CHARGES	20,603,344.57	231,077.64

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	275,960.94	ADJUSTMENTS	0.00
COVERED CHARGES	272,685.94	CONTRACTUAL ALLOW	164,130.64
NON-COVERD CHARGES	3,275.00	TOTAL MEDICAID LIAB	108,555.30
		LESS: COB	108,555.30
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 18

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	49		0	45,080.00		2,695.00
ROUTINE NURSERY	3		0	2,070.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	52		0	47,150.00		2,695.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	4		0	9,264.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	9,264.00		0.00
TOTAL ACCOMODATIONS	56		0	56,414.00		2,695.00

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,880.02	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	11,310.92	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	27,832.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,286.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,481.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,829.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,604.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	29,548.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	40,678.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,765.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,712.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,112.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	23,037.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,824.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	921.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	744.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,278.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,744.00	580.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,686.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	216,271.94	580.00
			TOTAL ACCOMODATIONS	56,414.00	2,695.00
			TOTAL CHARGES	272,685.94	3,275.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,179,055.20	ADJUSTMENTS	534,440.33
COVERED CHARGES	12,821,039.34	CONTRACTUAL ALLOW	10,227,874.11
NON-COVERD CHARGES	2,358,015.86	TOTAL MEDICAID LIAB	2,593,165.23
		LESS: COB	63,042.95
		LESS: COPAYMENT	4,197.00
		REIMBURSEMENT	2,525,925.28
		ALL OTHER	2,350,979.52
		FEE SCHEDULE-LAB	123,835.90
		INJECTABLE DRUGS	51,109.86

TOTAL NUMBER OF CLAIMS 4,093

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	352,178.86	38,196.16	OTHER LAB	103,419.00	1,237.00
MED/SURG SUPPLY	227,024.66	69,058.42	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	83.00	EDUCATION & TRAINING	0.00	1,215.00
RADIOLOGY-DIAGNOSTIC	813,072.00	14,344.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,932,960.00	655,734.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	26,002.00	8,917.04	FEE SCHEDULE LAB	1,562,166.50	312,561.80
EKG/ECG	231,384.00	4,464.00	MRI SERVICES	324,218.00	21,727.00
IV THERAPY	75,726.00	4,445.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	757,409.00	134,485.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	92,932.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	72,364.00	22,767.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	133,084.00	975.00	AMBULANCE	0.00	0.00
GI SERVICES	508,744.00	99,796.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,979,210.00	111,557.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	285,972.00	1,704.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	313,305.42	387,406.71
RADIOLOGY THERAPEUTIC	431,838.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,936.00	11,766.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,059.00	2,223.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	7,128.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	36,366.00	9,672.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	12,632.29	49,035.73
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	240.00	6,244.00
OTHER IMAGING SERVICE	501,576.00	221,099.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	93,880.00	27,384.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	180,534.00	18,483.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	384,937.00	93,016.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	78,993.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	298,876.61	21,292.00			
			TOTAL ANCILLARY	12,821,039.34	2,358,015.86
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,821,039.34	2,358,015.86

Report : CLM-0804-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
336	2214097003169	09/05/13 - 09/05/13	04/14/14	0.00	1,028.00	0.00	0.00	0.00
491	5914097000397	07/05/13 - 07/05/13	04/14/14	0.00	1,304.00	0.00	0.00	0.00
491	5914097000397	07/12/13 - 07/12/13	04/14/14	0.00	1,304.00	0.00	0.00	0.00
491	5914097000397	07/13/13 - 07/13/13	04/14/14	0.00	1,304.00	0.00	0.00	0.00
491	5914097000397	07/20/13 - 07/20/13	04/14/14	0.00	1,304.00	0.00	0.00	0.00
-1	9815010000073	09/11/13 - 09/11/13	01/19/15	240.00	0.00	0.00	0.00	0.00
TOTAL				240.00	6,244.00	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	341,717.73	ADJUSTMENTS	0.00
COVERED CHARGES	247,977.94	CONTRACTUAL ALLOW	147,153.16
NON-COVERD CHARGES	93,739.79	TOTAL MEDICAID LIAB	100,824.78
		LESS: COB	100,737.78
		LESS: COPAYMENT	87.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 88

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,964.79	1,415.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,665.42	2,053.88	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,553.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,873.00	43,577.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	31,026.00	6,877.00
EKG/ECG	3,348.00	0.00	MRI SERVICES	3,188.00	0.00
IV THERAPY	3,341.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	27,046.00	6,923.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,040.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	524.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,875.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	12,801.00	6,826.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	62,874.00	2,208.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,167.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,029.83	4,539.91
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	395.00	1,586.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	776.00	372.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	704.90	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,370.00	3,766.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,216.00	1,304.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,790.00	876.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,843.00	9,484.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	12,865.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,702.00	1,932.00			
			TOTAL ANCILLARY	247,977.94	93,739.79
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	247,977.94	93,739.79

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	696,726.16	ADJUSTMENTS	317.64
COVERED CHARGES	623,284.97	CONTRACTUAL ALLOW	594,935.16
NON-COVERD CHARGES	73,441.19	TOTAL MEDICAID LIAB	28,349.81
		LESS: COB	1,274.85
		LESS: COPAYMENT	786.01
		REIMBURSEMENT	26,288.95
		TOTAL NUMBER OF CLAIMS	484

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,286.56	525.50	OTHER LAB	6,007.00	0.00
MED/SURG SUPPLY	817.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	63,798.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	32,244.00	30,206.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	112,545.00	14,277.00
EKG/ECG	12,276.00	372.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,263.00	188.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	352,550.00	3,506.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,336.41	4,804.69
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	186.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	22,088.00	19,376.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,074.00	0.00			
			TOTAL ANCILLARY	623,284.97	73,441.19
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	623,284.97	73,441.19

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,329.89	ADJUSTMENTS	0.00
COVERED CHARGES	7,630.80	CONTRACTUAL ALLOW	4,397.74
NON-COVERD CHARGES	1,699.09	TOTAL MEDICAID LIAB	3,233.06
		LESS: COB	3,230.06
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	7

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	160.80	0.00	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	882.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,395.00	160.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,139.00	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	100.09
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	1,439.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,630.80	1,699.09
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,630.80	1,699.09

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII

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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 07/01/13 THROUGH 06/30/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,135,207.33	ADJUSTMENTS	46,450.04
COVERED CHARGES	1,933,627.60	CONTRACTUAL ALLOW	1,683,456.28
NON-COVERD CHARGES	201,579.73	TOTAL MEDICAID LIAB	250,171.32
		LESS: COB	5,629.32
		LESS: COPAYMENT	588.00
		REIMBURSEMENT	243,954.00
		TOTAL NUMBER OF CLAIMS	47

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 07/01/13 THROUGH 06/30/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	197,595.26	5,622.95	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	70,376.48	10,550.96	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,338.00	14,530.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	78,252.00	7,837.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	18,050.00	5,470.00
EKG/ECG	2,232.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	66,092.00	2,027.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	188,759.00	23,798.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	243.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	39,924.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,115.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	42,927.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	708,012.78	31,314.82
RADIOLOGY THERAPEUTIC	356,379.00	4,745.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	74,614.08	87,824.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,349.00	1,414.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	15,776.00	5,216.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	11,181.00	624.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	606.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	26,412.00	0.00			
			TOTAL ANCILLARY	1,933,627.60	201,579.73
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,933,627.60	201,579.73

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

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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	07/01/13	THROUGH	06/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

THE SPECIALTY HOSPITAL
 320 TURNER MCCALL BLVD SW
 ROME,GA 30165-5621

PROVIDER NUMBER 000886179A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,180,043.34	ADJUSTMENTS	224,754.43
COVERED CHARGES	3,739,010.84	CONTRACTUAL ALLOW	2,883,615.46
NON-COVERD CHARGES	2,441,032.50	TOTAL MEDICAID LIAB	855,395.38
		LESS: COB	588.71
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	854,806.67

TOTAL NUMBER OF ADMISSIONS 35

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	530		475	367,290.00		2,294,294.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	530		475	367,290.00		2,294,294.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	530		475	367,290.00		2,294,294.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

THE SPECIALTY HOSPITAL
 320 TURNER MCCALL BLVD SW
 ROME,GA 30165-5621

PROVIDER NUMBER
 000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	836,645.82	8.00	OTHER LAB	7,094.00	0.00
MED/SURG SUPPLY	526,875.50	4,902.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	519,910.00	45,625.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	51,120.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,667.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	321,276.03	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,600.00	0.00	MRI SERVICES	14,032.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	111,530.49	2,383.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	739,639.00	91,200.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	16,805.00	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	394.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	103,682.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	56,701.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	4,176.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,911.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	15,890.00	1,766.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,935.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	15,245.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,592.00	854.00			
			TOTAL ANCILLARY	3,371,720.84	146,738.50
			TOTAL ACCOMODATIONS	367,290.00	2,294,294.00
			TOTAL CHARGES	3,739,010.84	2,441,032.50

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

THE SPECIALTY HOSPITAL
320 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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THE SPECIALTY HOSPITAL
320 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

THE SPECIALTY HOSPITAL
320 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000886179A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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THE SPECIALTY HOSPITAL
320 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

THE SPECIALTY HOSPITAL
320 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000886179A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE SPECIALTY HOSPITAL
320 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000886179A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE SPECIALTY HOSPITAL
320 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000886179A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

SELECT SPECIALTY HOSPITAL ATLANTA
 550 PEACHTREE ST NE 7TH FL
 ATLANTA,GA 30308-2247

PROVIDER NUMBER 000916781A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,394,119.53	ADJUSTMENTS	0.00
COVERED CHARGES	1,947,509.18	CONTRACTUAL ALLOW	1,485,721.09
NON-COVERD CHARGES	446,610.35	TOTAL MEDICAID LIAB	461,788.09
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	461,788.09

TOTAL NUMBER OF ADMISSIONS 14

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	414		174	420,210.00		407,337.32
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	414		174	420,210.00		407,337.32
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	414		174	420,210.00		407,337.32

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

SELECT SPECIALTY HOSPITAL ATLANTA
 550 PEACHTREE ST NE 7TH FL
 ATLANTA,GA 30308-2247

PROVIDER NUMBER
 000916781A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/14 THROUGH 12/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	288,142.97	0.00	OTHER LAB	11,676.26	0.00
MED/SURG SUPPLY	302,346.84	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	65,234.01	0.00	EDUCATION & TRAINING	7,618.80	0.00
RADIOLOGY-DIAGNOSTIC	13,484.73	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	39,273.03	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	16,569.61	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	118,713.27	0.00	MRI SERVICES	8,079.31	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	43,301.79	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	601,331.63	0.00	FREE STANDING CLINIC	0.00	0.00
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	184.01	0.00	INJECTABLE DRUGS	1,364.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	21,084.83	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	11,158.71	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,396.64	0.00			
BLOOD	2,344.38	0.00			
BLOOD STORAGE & PRO.	10,398.39	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,869.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,527,299.18	39,273.03
			TOTAL ACCOMODATIONS	420,210.00	407,337.32
			TOTAL CHARGES	1,947,509.18	446,610.35

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

SELECT SPECIALTY HOSPITAL ATLANTA
550 PEACHTREE ST NE 7TH FL
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000916781A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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SELECT SPECIALTY HOSPITAL ATLANTA
550 PEACHTREE ST NE 7TH FL
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000916781A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SELECT SPECIALTY HOSPITAL ATLANTA
550 PEACHTREE ST NE 7TH FL
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000916781A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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SELECT SPECIALTY HOSPITAL ATLANTA
550 PEACHTREE ST NE 7TH FL
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000916781A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SELECT SPECIALTY HOSPITAL ATLANTA
550 PEACHTREE ST NE 7TH FL
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000916781A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/14 THROUGH 12/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SELECT SPECIALTY HOSPITAL ATLANTA
550 PEACHTREE ST NE 7TH FL
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000916781A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SELECT SPECIALTY HOSPITAL ATLANTA
550 PEACHTREE ST NE 7TH FL
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000916781A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/14	THROUGH	12/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

EMORY JOHNS CREEK HOSPITAL
 5707 PEACHTREE PKWY
 NORCROSS,GA 30092-2804

PROVIDER NUMBER 344886600A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,358,616.38	ADJUSTMENTS	62,469.52
COVERED CHARGES	7,110,291.62	CONTRACTUAL ALLOW	4,626,325.78
NON-COVERD CHARGES	248,324.76	TOTAL MEDICAID LIAB	2,483,965.84
		LESS: COB	78,748.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,405,217.43

TOTAL NUMBER OF ADMISSIONS 309

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,011		0	1,238,475.00		60,660.00
ROUTINE NURSERY	119		19	119,940.00		22,340.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,130		19	1,358,415.00		83,000.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	110		0	486,515.00		0.00
NICU	162		0	460,080.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	272		0	946,595.00		0.00
TOTAL ACCOMODATIONS	1,402		19	2,305,010.00		83,000.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

EMORY JOHNS CREEK HOSPITAL
 5707 PEACHTREE PKWY
 NORCROSS,GA 30092-2804

PROVIDER NUMBER
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	280,651.54	0.00	OTHER LAB	23,489.00	0.00
MED/SURG SUPPLY	435,921.00	280.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	697,298.45	653.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	164,316.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	353,242.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	96,139.32	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	21,615.00	0.00	MRI SERVICES	219,378.00	0.00
IV THERAPY	3,783.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	467,278.00	84,321.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	267,552.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	185,264.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	65,127.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	54,400.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	275,686.40	109.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	57,869.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	3,150.76
LABORATORY PATHOLOGIC	23,834.15	0.00	INJECTABLE DRUGS	523,142.54	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	54,633.20	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	20,968.02	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	51,774.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	40.00	204.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	87,552.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	73,659.00
OTHER IMAGING SERVICE	23,020.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	48,577.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	21,562.00	2,948.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	262,822.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,987.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,360.00	0.00			
			TOTAL ANCILLARY	4,805,281.62	165,324.76
			TOTAL ACCOMODATIONS	2,305,010.00	83,000.00
			TOTAL CHARGES	7,110,291.62	248,324.76

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE I
 INPATIENT PAID CLAIMS

Run Date: 07/15/2015
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EMORY JOHNS CREEK HOSPITAL
 5707 PEACHTREE PKWY
 NORCROSS,GA 30092-2804

PROVIDER NUMBER
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	9114174012059	01/14/14 - 01/16/14	07/14/14	0.00	2,841.00	0.00	817.70	0.00
614	2014197018471	06/22/14 - 06/24/14	07/21/14	0.00	12,564.00	0.00	0.00	0.00
615	9114248004278	06/09/14 - 06/11/14	01/12/15	0.00	11,228.00	0.00	3,128.72	0.00
614	2014269032731	06/04/14 - 06/09/14	09/29/14	0.00	6,273.00	0.00	0.00	0.00
615	9114282004301	05/20/14 - 05/30/14	10/27/14	0.00	16,970.00	0.00	4,210.33	0.00
615	2314338000055	07/08/14 - 07/11/14	12/29/14	0.00	11,228.00	0.00	0.00	0.00
614	2014340018907	06/17/14 - 06/24/14	12/15/14	0.00	6,282.00	0.00	0.00	0.00
614	9115029001701	07/07/14 - 07/23/14	02/16/15	0.00	6,273.00	0.00	2,670.47	0.00
TOTAL				0.00	73,659.00	0.00	10,827.22	0.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

EMORY JOHNS CREEK HOSPITAL
 5707 PEACHTREE PKWY
 NORCROSS,GA 30092-2804

PROVIDER NUMBER 344886600A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	103,569.98	ADJUSTMENTS	0.00
COVERED CHARGES	102,489.98	CONTRACTUAL ALLOW	70,367.47
NON-COVERD CHARGES	1,080.00	TOTAL MEDICAID LIAB	32,122.51
		LESS: COB	32,122.51
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	18		0	22,050.00		1,080.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	18		0	22,050.00		1,080.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	2		0	8,810.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2		0	8,810.00		0.00
TOTAL ACCOMODATIONS	20		0	30,860.00		1,080.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

EMORY JOHNS CREEK HOSPITAL
 5707 PEACHTREE PKWY
 NORCROSS,GA 30092-2804

PROVIDER NUMBER
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,498.86	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,950.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,434.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,085.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,788.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	866.00	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	7,670.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	18,321.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,589.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,006.00	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	1,458.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	410.00	0.00	INJECTABLE DRUGS	4,330.12	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	729.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,431.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	64.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	71,629.98	0.00
			TOTAL ACCOMODATIONS	30,860.00	1,080.00
			TOTAL CHARGES	102,489.98	1,080.00

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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EMORY JOHNS CREEK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,619,135.08	ADJUSTMENTS	73,955.94
COVERED CHARGES	2,066,178.29	CONTRACTUAL ALLOW	1,582,598.03
NON-COVERD CHARGES	552,956.79	TOTAL MEDICAID LIAB	483,580.26
		LESS: COB	221.95
		LESS: COPAYMENT	1,233.00
		REIMBURSEMENT	482,125.31
		ALL OTHER	442,803.80
		FEE SCHEDULE-LAB	31,809.57
		INJECTABLE DRUGS	7,511.94

TOTAL NUMBER OF CLAIMS 843

EMORY JOHNS CREEK HOSPITAL
 5707 PEACHTREE PKWY
 NORCROSS,GA 30092-2804

PROVIDER NUMBER
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,744.22	50,455.86	OTHER LAB	35,545.00	0.00
MED/SURG SUPPLY	108,742.00	7,974.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	983.00	EDUCATION & TRAINING	0.00	200.00
RADIOLOGY-DIAGNOSTIC	121,432.00	12,795.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	324,307.00	97,386.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,752.00	5,587.03	FEE SCHEDULE LAB	268,969.55	32,379.40
EKG/ECG	18,209.00	262.00	MRI SERVICES	141,190.00	45,048.00
IV THERAPY	543.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	121,213.00	50,882.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,027.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,652.00	1,160.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	30,260.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	67,779.00	21,995.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	347,432.00	8,164.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	33,926.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	35,496.52	41,782.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,808.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	240.00	2,611.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,485.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	14,688.00	240.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	879.00	10,227.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	17,510.00
OTHER IMAGING SERVICE	59,494.00	3,586.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,768.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	82,167.00	18,903.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	139,158.00	112,980.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	34,578.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	43,987.00	2,268.00			
			TOTAL ANCILLARY	2,066,178.29	551,671.79
			TOTAL ACCOMODATIONS	0.00	1,285.00
			TOTAL CHARGES	2,066,178.29	552,956.79

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/15/2015
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EMORY JOHNS CREEK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014121055464	04/24/14 - 04/24/14	05/05/14	0.00	6,282.00	0.00	0.00	0.00
615	2014184026359	06/22/14 - 06/22/14	07/07/14	0.00	5,614.00	0.00	0.00	0.00
615	2014184026359	06/22/14 - 06/22/14	07/07/14	0.00	5,614.00	0.00	0.00	0.00
TOTAL				0.00	17,510.00	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

Run Date: 07/15/2015
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY JOHNS CREEK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	68,792.97	ADJUSTMENTS	0.00
COVERED CHARGES	33,265.07	CONTRACTUAL ALLOW	3,863.01
NON-COVERD CHARGES	35,527.90	TOTAL MEDICAID LIAB	29,402.06
		LESS: COB	29,367.86
		LESS: COPAYMENT	34.20
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 20

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY JOHNS CREEK HOSPITAL
 5707 PEACHTREE PKWY
 NORCROSS,GA 30092-2804

PROVIDER NUMBER
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	434.12	562.49	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	898.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,100.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,560.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	3,407.00	FEE SCHEDULE LAB	5,000.00	205.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,665.00	12,545.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,978.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,318.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,718.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	635.95	140.41
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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,170.00	15,677.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	952.00	143.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	1,288.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	6,396.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	33,265.07	35,527.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	33,265.07	35,527.90

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/15/2015
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EMORY JOHNS CREEK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	90,770.00	ADJUSTMENTS	161.82
COVERED CHARGES	80,345.79	CONTRACTUAL ALLOW	76,094.35
NON-COVERD CHARGES	10,424.21	TOTAL MEDICAID LIAB	4,251.44
		LESS: COB	0.00
		LESS: COPAYMENT	162.00
		REIMBURSEMENT	4,089.44
		TOTAL NUMBER OF CLAIMS	76

Report : CLM-0808-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY JOHNS CREEK HOSPITAL
 5707 PEACHTREE PKWY
 NORCROSS,GA 30092-2804

PROVIDER NUMBER
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	116.74	863.10	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	227.00	675.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,390.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,486.00	1,560.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,472.70	908.30
EKG/ECG	655.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	191.00	116.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,377.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	40,399.00	192.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	580.35	2,545.81
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	204.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,238.00	1,187.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,386.00	0.00			
			TOTAL ANCILLARY	80,345.79	10,424.21
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	80,345.79	10,424.21

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY JOHNS CREEK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,615.40	ADJUSTMENTS	0.00
COVERED CHARGES	11,733.70	CONTRACTUAL ALLOW	7,874.41
NON-COVERD CHARGES	881.70	TOTAL MEDICAID LIAB	3,859.29
		LESS: COB	3,841.29
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY JOHNS CREEK HOSPITAL
 5707 PEACHTREE PKWY
 NORCROSS,GA 30092-2804

PROVIDER NUMBER
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 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	575.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,731.10	583.10
EKG/ECG	131.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,322.00	109.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	40.60	189.60
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	1,934.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	11,733.70	881.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,733.70	881.70

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY JOHNS CREEK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/13 THROUGH 08/31/14
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	83,248.90	ADJUSTMENTS	0.00
COVERED CHARGES	80,148.30	CONTRACTUAL ALLOW	63,829.79
NON-COVERD CHARGES	3,100.60	TOTAL MEDICAID LIAB	16,318.51
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	16,315.51

TOTAL NUMBER OF CLAIMS 3

Report : CLM-0812-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/15/2015
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SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY JOHNS CREEK HOSPITAL
 5707 PEACHTREE PKWY
 NORCROSS,GA 30092-2804

PROVIDER NUMBER
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/13 THROUGH 08/31/14
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	440.41	316.23	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	22,420.00	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	895.00	0.00
EKG/ECG	131.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	35,295.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,231.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	432.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,009.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	304.89	396.37
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	7,990.00	2,388.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	80,148.30	3,100.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	80,148.30	3,100.60

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 07/15/2015
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY JOHNS CREEK HOSPITAL
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
344886600A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/13	THROUGH	08/31/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **