

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 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,884,154.62	ADJUSTMENTS	325,356.54
COVERED CHARGES	8,793,700.59	CONTRACTUAL ALLOW	6,089,434.68
NON-COVERD CHARGES	90,454.03	TOTAL MEDICAID LIAB	2,704,265.91
		LESS: COB	45,264.23
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,659,001.68

TOTAL NUMBER OF ADMISSIONS 348

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,099		0	606,488.00		55,858.00
ROUTINE NURSERY	87		0	43,335.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,186		0	649,823.00		55,858.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	222		0	261,984.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	222		0	261,984.00		0.00
TOTAL ACCOMODATIONS	1,408		0	911,807.00		55,858.00

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 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,283,009.47	0.00	OTHER LAB	26,021.79	0.00
MED/SURG SUPPLY	863,356.17	85.76	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	896,604.04	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	157,430.24	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	333,438.41	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	94,007.31	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	36,164.28	0.00	MRI SERVICES	59,774.20	0.00
IV THERAPY	31,562.47	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	612,608.21	1,035.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	66,249.76	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	479,657.12	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	177,138.42	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	444,504.30	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	141,095.72	0.00	DRUG-SPECIFIC/HOME IV	0.00	6,888.96
LABORATORY PATHOLOGIC	41,829.50	0.00	INJECTABLE DRUGS	1,186,822.68	0.00
RADIOLOGY THERAPEUTIC	1,565.62	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,104.05	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	15,828.62	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	5,101.81	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	598,795.89	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	27,239.89	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	92,530.26	12,948.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,177.25	0.00			
AUDIOLOGY	12,504.90	0.00			
CARDIOLOGY	100,204.84	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,429.02	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	79,239.16	8,536.50			
			TOTAL ANCILLARY	7,881,893.59	34,596.03
			TOTAL ACCOMODATIONS	911,807.00	55,858.00
			TOTAL CHARGES	8,793,700.59	90,454.03

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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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 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	62,058.40	ADJUSTMENTS	0.00
COVERED CHARGES	56,067.90	CONTRACTUAL ALLOW	13,145.10
NON-COVERD CHARGES	5,990.50	TOTAL MEDICAID LIAB	42,922.80
		LESS: COB	42,922.80
		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	2,208.00		3,913.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	4		0	2,208.00		3,913.00
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	4		0	2,208.00		3,913.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

PHOEBE SUMTER MEDICAL CENTER
 126 US HWY 280 W
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 SERVICE DATES 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,408.59	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,887.86	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,674.76	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,012.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,189.01	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	2,077.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,789.87	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,979.59	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	878.65	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,587.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	525.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	389.55	0.00	INJECTABLE DRUGS	13,888.31	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	479.85	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	169.36	0.00			
			TOTAL ANCILLARY	53,859.90	2,077.50
			TOTAL ACCOMODATIONS	2,208.00	3,913.00
			TOTAL CHARGES	56,067.90	5,990.50

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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 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 08/01/15 THROUGH 07/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,168,326.13	ADJUSTMENTS	440,208.76
COVERED CHARGES	8,389,834.10	CONTRACTUAL ALLOW	6,156,457.64
NON-COVERD CHARGES	778,492.03	TOTAL MEDICAID LIAB	2,233,376.46
		LESS: COB	1,839.17
		LESS: COPAYMENT	4,837.11
		REIMBURSEMENT	2,226,700.18
		ALL OTHER	1,991,812.52
		FEE SCHEDULE-LAB	130,734.20
		INJECTABLE DRUGS	104,153.46

TOTAL NUMBER OF CLAIMS 4,051

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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 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 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	508,225.66	2,621.79	OTHER LAB	48,241.66	3,682.79
MED/SURG SUPPLY	325,073.74	1,298.52	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	354,759.17	14,861.71	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,017,194.11	138,454.84	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	79,365.46	9,375.35	FEE SCHEDULE LAB	746,080.64	47,945.32
EKG/ECG	68,757.58	10,900.43	MRI SERVICES	307,645.57	50,179.20
IV THERAPY	290,091.69	24,520.52	PROFESSIONAL FEES	0.00	1,576.00
OPERATING ROOM	697,857.20	62,839.62	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	12,643.18	469.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,666.39	8,260.85	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	191,961.80	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,561,174.64	11,528.29	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	348,640.20	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,242,486.37	304,791.03
RADIOLOGY THERAPEUTIC	100,832.63	165.18	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	552.26	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,590.21	2,915.17	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	29,372.33	1,506.58	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	49,368.68	15,830.78
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	174,758.68	29,081.07			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,117.95	6,352.30			
ONCOLOGY	1,373.74	0.00			
NUCLEAR MEDICINE	39,618.91	12,192.83			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	54,275.86	15,080.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	46,725.96	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	61,381.83	2,062.86			
			TOTAL ANCILLARY	8,389,834.10	778,492.03
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,389,834.10	778,492.03

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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

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 08/01/15 THROUGH 07/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	192,639.86	ADJUSTMENTS	0.00
COVERED CHARGES	109,625.93	CONTRACTUAL ALLOW	-5,634.38
NON-COVERD CHARGES	83,013.93	TOTAL MEDICAID LIAB	115,260.31
		LESS: COB	115,219.18
		LESS: COPAYMENT	41.13
		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

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 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,022.62	455.10	OTHER LAB	753.58	0.00
MED/SURG SUPPLY	3,758.52	18.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,010.08	280.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,168.00	19,162.63	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,821.28	280.00
EKG/ECG	206.00	412.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,508.00	678.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,732.50	9,618.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,747.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	168.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,726.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,156.84	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,500.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	38,997.26	41,008.67
RADIOLOGY THERAPEUTIC	3,707.12	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	494.03	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	85.01	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,439.85	2,768.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	7,839.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,118.27	0.00			
			TOTAL ANCILLARY	109,625.93	83,013.93
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	109,625.93	83,013.93

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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 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 08/01/15 THROUGH 07/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	334,166.69	ADJUSTMENTS	920.98
COVERED CHARGES	325,371.24	CONTRACTUAL ALLOW	306,139.66
NON-COVERD CHARGES	8,795.45	TOTAL MEDICAID LIAB	19,231.58
		LESS: COB	314.12
		LESS: COPAYMENT	717.37
		REIMBURSEMENT	18,200.09
		TOTAL NUMBER OF CLAIMS	342

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

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

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PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,154.21	264.67	OTHER LAB	780.50	0.00
MED/SURG SUPPLY	6,569.97	563.91	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	23,734.01	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	45,788.45	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,859.00	749.74	FEE SCHEDULE LAB	28,897.53	922.86
EKG/ECG	1,072.00	206.00	MRI SERVICES	0.00	0.00
IV THERAPY	226.00	0.00	PROFESSIONAL FEES	0.00	394.00
OPERATING ROOM	1,407.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	886.00	130.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	167,082.38	467.55	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,475.40	4,926.74
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	90.42	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	1.98
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,116.37	168.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	232.00	0.00			
			TOTAL ANCILLARY	325,371.24	8,795.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	325,371.24	8,795.45

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 08/01/15 THROUGH 07/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,725.16	ADJUSTMENTS	0.00
COVERED CHARGES	5,568.35	CONTRACTUAL ALLOW	2,388.62
NON-COVERD CHARGES	1,156.81	TOTAL MEDICAID LIAB	3,179.73
		LESS: COB	3,173.73
		LESS: COPAYMENT	6.00
		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: 08/24/2017
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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 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6.59	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	132.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	393.23	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	830.00	39.81
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,624.73	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	91.50	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	490.00	1,117.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	5,568.35	1,156.81
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,568.35	1,156.81

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 08/01/15 THROUGH 07/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,374,311.15	ADJUSTMENTS	114,929.29
COVERED CHARGES	2,307,191.43	CONTRACTUAL ALLOW	1,938,908.43
NON-COVERD CHARGES	67,119.72	TOTAL MEDICAID LIAB	368,283.00
		LESS: COB	0.00
		LESS: COPAYMENT	407.87
		REIMBURSEMENT	367,875.13

TOTAL NUMBER OF CLAIMS 64

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 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	80,354.20	3,423.20	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	173,844.99	167.14	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,920.23	2,833.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	30,175.98	6,016.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,260.00	FEE SCHEDULE LAB	31,003.64	1,485.81
EKG/ECG	1,064.45	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	76,339.01	2,960.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	194,771.02	42,672.76	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	214.00	277.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	78,290.40	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,080.75	1,221.57	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	75,460.76	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,310,631.50	3,549.79
RADIOLOGY THERAPEUTIC	64,659.55	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	1,420.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	153,041.63	145.83
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	739.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,622.90	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,081.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,476.42	1,107.62			
			TOTAL ANCILLARY	2,307,191.43	67,119.72
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,307,191.43	67,119.72

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

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	08/01/15	THROUGH	07/31/16
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,311,799.00	ADJUSTMENTS	157,099.30
COVERED CHARGES	2,226,044.96	CONTRACTUAL ALLOW	1,206,456.43
NON-COVERD CHARGES	85,754.04	TOTAL MEDICAID LIAB	1,019,588.53
		LESS: COB	14,860.72
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,004,727.81

TOTAL NUMBER OF ADMISSIONS 211

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,183		0	589,134.00		67,932.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,183		0	589,134.00		67,932.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	85		0	97,844.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	85		0	97,844.00		0.00
TOTAL ACCOMODATIONS	1,268		0	686,978.00		67,932.00

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	112,645.54	0.00	OTHER LAB	4,499.00	0.00
MED/SURG SUPPLY	59,295.63	245.12	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	446,433.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	23,736.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	99,807.60	5,644.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,785.05	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	32,800.00	0.00	MRI SERVICES	14,572.80	0.00
IV THERAPY	132,383.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,085.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	84,942.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,426.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,506.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	25,092.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,301.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	386,803.92	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,637.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	7,096.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,031.42	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	106.92
OTHER IMAGING SERVICE	1,415.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,202.00	11,826.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	13,257.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,672.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	27,643.00	0.00			
			TOTAL ANCILLARY	1,539,066.96	17,822.04
			TOTAL ACCOMODATIONS	686,978.00	67,932.00
			TOTAL CHARGES	2,226,044.96	85,754.04

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: 08/24/2017
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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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
32	2216089002704	03/17/16 - 03/23/16	04/04/16	0.00	65.00	0.00	0.00	0.00
70	2216182012432	06/22/16 - 06/23/16	07/04/16	0.00	41.92	0.00	0.00	0.00
TOTAL				0.00	106.92	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: 08/24/2017
Run Time: 01:57:54
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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	09/01/15	THROUGH	08/31/16
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: 08/24/2017
Run Time: 01:57:54
Page: 5

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

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,668,898.31	ADJUSTMENTS	140,803.22
COVERED CHARGES	1,560,461.71	CONTRACTUAL ALLOW	1,192,847.51
NON-COVERD CHARGES	108,436.60	TOTAL MEDICAID LIAB	367,614.20
		LESS: COB	341.33
		LESS: COPAYMENT	1,155.00
		REIMBURSEMENT	366,117.87
		ALL OTHER	314,301.94
		FEE SCHEDULE-LAB	46,816.20
		INJECTABLE DRUGS	4,999.73
		TOTAL NUMBER OF CLAIMS	1,284

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: 08/24/2017
 Run Time: 01:57:54
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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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,670.56	1,461.74	OTHER LAB	9,295.00	0.00
MED/SURG SUPPLY	42,133.33	313.59	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	200.00	EDUCATION & TRAINING	0.00	56.00
RADIOLOGY-DIAGNOSTIC	80,389.00	163.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	207,777.00	35,551.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,097.00	1,764.03	FEE SCHEDULE LAB	447,714.00	22,767.00
EKG/ECG	28,690.00	225.00	MRI SERVICES	37,349.60	0.00
IV THERAPY	174,675.00	2,480.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,841.00	783.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	27,434.00	10,395.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,803.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	18,355.00	4,515.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	197,215.32	1,441.68	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,915.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	28,765.90	10,432.35
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,743.00	826.04	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,412.00	412.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	518.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	375.00	198.14
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	88.03
OTHER IMAGING SERVICE	21,910.00	797.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,786.00	2,628.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	25,462.00	5,000.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	24,723.00	4,451.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,184.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	77,747.00	970.00			
			TOTAL ANCILLARY	1,560,461.71	108,436.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,560,461.71	108,436.60

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: 08/24/2017
Run Time: 01:57:54
Page: 7

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

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
1302	2316228000144	07/25/16 - 07/25/16	08/22/16	0.00	61.00	0.00	0.00	0.00
626	2216284005369	08/01/16 - 08/01/16	10/17/16	0.00	27.03	0.00	82.74	0.00
TOTAL				0.00	88.03	0.00	82.74	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: 08/24/2017
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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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	34,588.07	ADJUSTMENTS	0.00
COVERED CHARGES	30,856.78	CONTRACTUAL ALLOW	12,815.77
NON-COVERD CHARGES	3,731.29	TOTAL MEDICAID LIAB	18,041.01
		LESS: COB	18,008.01
		LESS: COPAYMENT	33.00
		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

APPLING HOSPITAL PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
 163 E TOLLISON ST 000000052A SERVICE DATES 09/01/15 THROUGH 08/31/16
 BAXLEY,GA 31513-0120 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	675.76	40.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	528.08	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,478.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,167.00	1,135.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,511.00	128.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,307.00	1,083.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	335.00	486.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,381.00	16.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	742.94	745.26
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	27.03
OTHER IMAGING SERVICE	523.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,208.00	71.00			
			TOTAL ANCILLARY	30,856.78	3,731.29
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	30,856.78	3,731.29

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: 08/24/2017
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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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
363	2216260006968	08/03/16 - 08/03/16	09/19/16	0.00	27.03	0.00	581.82	0.00
TOTAL				0.00	27.03	0.00	581.82	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: 08/24/2017
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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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	82,302.19	ADJUSTMENTS	105.88
COVERED CHARGES	81,606.89	CONTRACTUAL ALLOW	75,061.91
NON-COVERD CHARGES	695.30	TOTAL MEDICAID LIAB	6,544.98
		LESS: COB	0.00
		LESS: COPAYMENT	201.80
		REIMBURSEMENT	6,343.18
		TOTAL NUMBER OF CLAIMS	117

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,221.82	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	922.57	32.30	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,768.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,266.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	22,687.00	519.00
EKG/ECG	845.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,648.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	379.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	33,998.00	144.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,388.50	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	483.00	0.00			
			TOTAL ANCILLARY	81,606.89	695.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	81,606.89	695.30

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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	806.02	ADJUSTMENTS	0.00
COVERED CHARGES	806.02	CONTRACTUAL ALLOW	803.02
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

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 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	324.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	120.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	324.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	38.02	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	806.02	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	806.02	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

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

PROVIDER NUMBER
000000052A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/15	THROUGH	08/31/16
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: 08/24/2017
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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	09/01/15	THROUGH	08/31/16
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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	28,391,036.89	ADJUSTMENTS	420,503.08
COVERED CHARGES	27,105,398.89	CONTRACTUAL ALLOW	18,015,460.77
NON-COVERD CHARGES	1,285,638.00	TOTAL MEDICAID LIAB	9,089,938.12
		LESS: COB	61,581.31
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,028,356.81

TOTAL NUMBER OF ADMISSIONS 1,042

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5,008		0	3,041,582.00		816,672.00
ROUTINE NURSERY	72		0	39,845.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5,080		0	3,081,427.00		816,672.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	961		0	1,282,929.00		2,862.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		165	0.00		133,547.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	961		165	1,282,929.00		136,409.00
TOTAL ACCOMODATIONS	6,041		165	4,364,356.00		953,081.00

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,128,601.22	19,605.00	OTHER LAB	58,044.00	528.00
MED/SURG SUPPLY	1,863,712.00	3,258.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,387,876.00	13,778.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	604,535.00	792.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,091,340.00	45,676.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	264,671.83	512.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	125,352.00	0.00	MRI SERVICES	301,356.00	0.00
IV THERAPY	1,647.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,553,740.00	10,401.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	53,863.00	92.00	REHAB THERAPY	154.00	0.00
RESPIRATORY SERVICES	1,152,455.00	11,976.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	113,640.00	2,795.00	AMBULANCE	0.00	0.00
GI SERVICES	96,089.00	1,921.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,003,460.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	149,450.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	129,608.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	203,668.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	198,904.33	496.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	71,214.51	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	152,148.00	6,798.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	25,505.00	TRAUMA RESPONSE	0.00	6,087.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,696,065.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	91,522.00	9,518.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	236,566.00	172,230.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	74,132.00	0.00			
AUDIOLOGY	7,687.00	0.00			
CARDIOLOGY	831,043.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	20,933.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	77,566.00	589.00			
			TOTAL ANCILLARY	22,741,042.89	332,557.00
			TOTAL ACCOMODATIONS	4,364,356.00	953,081.00
			TOTAL CHARGES	27,105,398.89	1,285,638.00

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

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

Run Date: 08/24/2017
Run Time: 03:29:19
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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 10/01/15 THROUGH 09/30/16
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: 08/24/2017
Run Time: 03:29:20
Page: 4

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,119,538.38	ADJUSTMENTS	267,260.42
COVERED CHARGES	17,750,790.46	CONTRACTUAL ALLOW	13,755,099.71
NON-COVERD CHARGES	1,368,747.92	TOTAL MEDICAID LIAB	3,995,690.75
		LESS: COB	3,252.25
		LESS: COPAYMENT	16,295.65
		REIMBURSEMENT	3,976,142.85
		ALL OTHER	2,791,252.00
		FEE SCHEDULE-LAB	287,600.64
		INJECTABLE DRUGS	897,290.21

TOTAL NUMBER OF CLAIMS 9,088

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	316,670.32	4,105.00	OTHER LAB	112,218.00	0.00
MED/SURG SUPPLY	749,714.50	363.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	623,470.00	4,320.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,649,789.00	204,803.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	73,765.00	50,597.22	FEE SCHEDULE LAB	2,143,905.52	156,207.00
EKG/ECG	107,507.00	1,947.00	MRI SERVICES	394,152.00	11,403.00
IV THERAPY	1,139,512.50	15,601.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,109,322.81	178,983.19	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	36,502.00	0.00	REHAB THERAPY	0.00	308.00
RESPIRATORY SERVICES	123,092.00	28,971.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	111,592.00	5,275.00	AMBULANCE	0.00	0.00
GI SERVICES	242,253.04	78,458.96	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,036,067.25	2,164.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	228,670.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,780,322.02	293,305.71
RADIOLOGY THERAPEUTIC	1,787,123.00	30,915.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	19,367.00	23,871.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	316.00	2,530.09	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	154,257.00	3,322.00	TRAUMA RESPONSE	0.00	8,034.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	129,263.50	0.00
LITHOTRIPSY	21,636.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	427,772.00	35,907.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	39,059.00	8,525.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	268,374.00	53,660.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	389,785.00	129,375.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	156,719.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	378,594.00	35,796.00			
			TOTAL ANCILLARY	17,750,790.46	1,368,747.92
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,750,790.46	1,368,747.92

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

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	87,231.40	ADJUSTMENTS	0.00
COVERED CHARGES	58,433.40	CONTRACTUAL ALLOW	13,741.55
NON-COVERD CHARGES	28,798.00	TOTAL MEDICAID LIAB	44,691.85
		LESS: COB	44,626.01
		LESS: COPAYMENT	65.84
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 45

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,766.00	905.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,715.00	307.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,315.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,091.00	18,114.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,716.00	578.00
EKG/ECG	407.00	0.00	MRI SERVICES	0.00	2,168.00
IV THERAPY	5,789.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	2,327.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	696.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	352.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,119.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	698.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,572.40	503.00
RADIOLOGY THERAPEUTIC	3,894.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,236.00	807.00	TRAUMA RESPONSE	0.00	994.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	221.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	564.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	129.00	1,243.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,215.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,502.00	288.00			
			TOTAL ANCILLARY	58,433.40	28,798.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	58,433.40	28,798.00

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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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	343,678.00	ADJUSTMENTS	435.52
COVERED CHARGES	317,033.00	CONTRACTUAL ALLOW	299,915.36
NON-COVERD CHARGES	26,645.00	TOTAL MEDICAID LIAB	17,117.64
		LESS: COB	42.64
		LESS: COPAYMENT	377.09
		REIMBURSEMENT	16,697.91
		TOTAL NUMBER OF CLAIMS	306

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	488.00	771.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,398.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,823.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	43,409.00	9,583.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	84,133.00	2,505.00
EKG/ECG	1,610.00	0.00	MRI SERVICES	2,168.00	0.00
IV THERAPY	22,694.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,608.00	404.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	114,454.00	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	12,159.00	12,776.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	90.00	154.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,760.00	452.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,239.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	317,033.00	26,645.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	317,033.00	26,645.00

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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,625.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,612.00	CONTRACTUAL ALLOW	901.80
NON-COVERD CHARGES	13.00	TOTAL MEDICAID LIAB	710.20
		LESS: COB	707.20
		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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 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	332.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	478.00	13.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,612.00	13.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,612.00	13.00

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

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,720,102.58	ADJUSTMENTS	166,982.20
COVERED CHARGES	6,447,636.58	CONTRACTUAL ALLOW	5,658,419.64
NON-COVERD CHARGES	272,466.00	TOTAL MEDICAID LIAB	789,216.94
		LESS: COB	0.00
		LESS: COPAYMENT	492.00
		REIMBURSEMENT	788,724.94

TOTAL NUMBER OF CLAIMS 141

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,947.00	0.00	OTHER LAB	1,133.00	0.00
MED/SURG SUPPLY	225,288.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	53,328.00	20,180.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,075.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	802.00	FEE SCHEDULE LAB	43,523.00	1,318.00
EKG/ECG	3,115.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	125,424.00	3,560.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	402,670.00	88,944.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,634.00	5,120.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,124.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,680.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	28,583.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,482,002.08	106,120.00
RADIOLOGY THERAPEUTIC	427,968.00	31,488.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,192.00	55.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	510,267.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	449.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	978.00	489.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,624.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	52,896.00	13,154.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	26,736.00	1,236.00			
			TOTAL ANCILLARY	6,447,636.58	272,466.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,447,636.58	272,466.00

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: 08/24/2017
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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	10/01/15	THROUGH	09/30/16
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: 08/24/2017
 Run Time: 01:58:44
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	74,394,407.86	ADJUSTMENTS	2,485,258.22
COVERED CHARGES	70,172,965.37	CONTRACTUAL ALLOW	51,549,391.04
NON-COVERD CHARGES	4,221,442.49	TOTAL MEDICAID LIAB	18,623,574.33
		LESS: COB	138,348.21
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	18,485,226.12

TOTAL NUMBER OF ADMISSIONS 2,031

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7,192		0	7,092,747.00		2,889,369.00
ROUTINE NURSERY	1,101		0	1,564,172.00		513,093.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		74.00
TOTAL ROUTINE	8,293		0	8,656,919.00		3,402,536.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,218		0	3,442,646.41		47,602.59
NICU	161		0	531,300.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,379		0	3,973,946.41		47,602.59
TOTAL ACCOMODATIONS	9,672		0	12,630,865.41		3,450,138.59

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,827,274.94	82,824.29	OTHER LAB	372,179.00	2,658.00
MED/SURG SUPPLY	3,530,831.74	96,952.52	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,610,344.73	87,915.44	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,000,666.22	6,004.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,075,247.00	6,006.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	189,504.51	1,358.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,629,240.00	42,633.00	MRI SERVICES	484,321.00	2,011.00
IV THERAPY	828,431.00	2,156.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,709,279.00	62,386.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,963,312.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,503,089.00	75,832.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	267,399.00	2,565.00	AMBULANCE	0.00	0.00
GI SERVICES	458,554.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,898,849.00	2,015.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	372,765.00	950.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	521,051.87	405.00	INJECTABLE DRUGS	2,195,276.86	35,337.07
RADIOLOGY THERAPEUTIC	65,385.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	83,920.06	509.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	90,313.43	580.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	526,697.00	63,297.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,738.00	8,697.00	TRAUMA RESPONSE	0.00	72,330.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,873,838.03	100.70
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,642.00
OTHER IMAGING SERVICE	410,800.00	1,236.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	444,931.00	63,399.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	293,382.00	40,845.48			
AUDIOLOGY	53,406.00	0.00			
CARDIOLOGY	1,887,236.00	3,600.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	88,566.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	284,271.57	4,059.40			
			TOTAL ANCILLARY	57,542,099.96	771,303.90
			TOTAL ACCOMODATIONS	12,630,865.41	3,450,138.59
			TOTAL CHARGES	70,172,965.37	4,221,442.49

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: 08/24/2017
Run Time: 01:58:44
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2217111012426	02/22/16 - 04/13/16	04/24/17	0.00	1,321.00	0.00	0.00	0.00
615	2017193063127	02/28/16 - 03/04/16	07/17/17	0.00	1,321.00	0.00	0.00	0.00
TOTAL				0.00	2,642.00	0.00	0.00	0.00

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	429,626.22	ADJUSTMENTS	0.00
COVERED CHARGES	417,074.22	CONTRACTUAL ALLOW	199,987.07
NON-COVERD CHARGES	12,552.00	TOTAL MEDICAID LIAB	217,087.15
		LESS: COB	217,087.15
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 14

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	22		0	19,067.00		7,845.00
ROUTINE NURSERY	15		0	18,008.00		4,707.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	37		0	37,075.00		12,552.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	24		0	68,616.00		0.00
NICU	2		0	6,600.00		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	26		0	75,216.00		0.00
TOTAL ACCOMODATIONS	63		0	112,291.00		12,552.00

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

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

Run Date: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45,920.10	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	15,026.69	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	43,943.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,032.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,363.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	307.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	628.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	38,428.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	51,750.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	76,326.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,284.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,712.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	928.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,086.00	0.00	INJECTABLE DRUGS	9,506.43	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	852.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	891.00	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	0.00	0.00			
			TOTAL ANCILLARY	304,783.22	0.00
			TOTAL ACCOMODATIONS	112,291.00	12,552.00
			TOTAL CHARGES	417,074.22	12,552.00

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: 08/24/2017
Run Time: 02:00:09
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	33,136,628.90	ADJUSTMENTS	1,265,860.20
COVERED CHARGES	31,625,333.07	CONTRACTUAL ALLOW	26,244,655.95
NON-COVERD CHARGES	1,511,295.83	TOTAL MEDICAID LIAB	5,380,677.12
		LESS: COB	97,730.67
		LESS: COPAYMENT	10,210.63
		REIMBURSEMENT	5,272,735.82
		ALL OTHER	4,401,389.52
		FEE SCHEDULE-LAB	577,588.76
		INJECTABLE DRUGS	293,757.54

TOTAL NUMBER OF CLAIMS 12,001

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	622,676.11	689.00	OTHER LAB	332,764.00	918.00
MED/SURG SUPPLY	811,828.90	3,936.76	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	747.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,163,771.50	5,532.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,998,938.00	138,008.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	52,820.00	15,091.06	FEE SCHEDULE LAB	4,853,052.15	311,841.87
EKG/ECG	466,397.00	2,386.00	MRI SERVICES	572,628.00	13,328.00
IV THERAPY	1,713,694.00	967.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,083,070.00	65,239.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,822.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	187,115.67	40,991.33	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	156,025.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	286,290.00	9,699.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,622,433.00	9,262.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	347,008.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	3,300.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,695,929.37	435,191.32
RADIOLOGY THERAPEUTIC	198,973.00	122,700.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,398.00	2,533.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,578.00	4,774.21	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	99,003.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	99,003.16	8,673.00	TRAUMA RESPONSE	0.00	67,508.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	242,483.97	4,044.53
LITHOTRIPSY	57,630.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,086,309.00	64,594.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	83,147.00	2,923.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	573,191.00	23,733.20			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	732,512.00	41,876.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	371,722.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,194,123.24	11,806.05			
			TOTAL ANCILLARY	31,625,333.07	1,511,295.83
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	31,625,333.07	1,511,295.83

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

Run Date: 08/24/2017
Run Time: 02:03:13
Page: 8

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	431,896.17	ADJUSTMENTS	0.00
COVERED CHARGES	339,314.24	CONTRACTUAL ALLOW	167,573.92
NON-COVERD CHARGES	92,581.93	TOTAL MEDICAID LIAB	171,740.32
		LESS: COB	171,597.87
		LESS: COPAYMENT	142.45
		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

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,230.58	100.00	OTHER LAB	9,213.00	0.00
MED/SURG SUPPLY	18,110.16	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,179.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,061.00	8,807.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,785.00	337.00	FEE SCHEDULE LAB	45,681.93	1,304.93
EKG/ECG	2,149.00	0.00	MRI SERVICES	1,991.00	4,237.00
IV THERAPY	23,295.00	0.00	PROFESSIONAL FEES	0.00	58.00
OPERATING ROOM	50,279.00	54,759.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,210.00	135.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,343.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,832.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	80,299.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,761.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,807.13	6,084.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,190.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,034.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	156.54	10,976.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,370.00	2,952.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	15,951.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,217.90	0.00			
			TOTAL ANCILLARY	339,314.24	92,581.93
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	339,314.24	92,581.93

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: 08/24/2017
Run Time: 02:03:17
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	876,084.18	ADJUSTMENTS	535.40
COVERED CHARGES	847,896.14	CONTRACTUAL ALLOW	815,766.26
NON-COVERD CHARGES	28,188.04	TOTAL MEDICAID LIAB	32,129.88
		LESS: COB	1,414.15
		LESS: COPAYMENT	932.97
		REIMBURSEMENT	29,782.76
		TOTAL NUMBER OF CLAIMS	550

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

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

Run Date: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,510.77	0.00	OTHER LAB	1,676.00	0.00
MED/SURG SUPPLY	12,571.57	323.68	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	965.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	51,679.00	1,470.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	38,363.00	2,972.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	106,174.71	9,177.36
EKG/ECG	6,591.00	0.00	MRI SERVICES	4,153.00	2,088.00
IV THERAPY	40,851.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	19,328.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,021.00	495.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,009.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	886.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	516,039.00	2,031.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,991.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	24,562.10	8,331.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,246.18	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,227.00	335.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,016.81	0.00			
			TOTAL ANCILLARY	847,896.14	28,188.04
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	847,896.14	28,188.04

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: 08/24/2017
Run Time: 02:03:25
Page: 12

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,672.84	ADJUSTMENTS	0.00
COVERED CHARGES	7,626.84	CONTRACTUAL ALLOW	4,426.90
NON-COVERD CHARGES	46.00	TOTAL MEDICAID LIAB	3,199.94
		LESS: COB	3,190.94
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	7

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 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	1,198.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	308.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,815.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	305.84	46.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,626.84	46.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,626.84	46.00

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

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

Run Date: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,172,249.17	ADJUSTMENTS	151,686.69
COVERED CHARGES	3,029,576.95	CONTRACTUAL ALLOW	2,626,257.14
NON-COVERD CHARGES	142,672.22	TOTAL MEDICAID LIAB	403,319.81
		LESS: COB	5,007.83
		LESS: COPAYMENT	615.00
		REIMBURSEMENT	397,696.98

TOTAL NUMBER OF CLAIMS 71

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

ATHENS REGIONAL MEDICAL CTR	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
1199 PRINCE AVE	000000074A	SERVICE DATES	10/01/15	THROUGH	09/30/16
ATHENS,GA 30606-2797		ADMISSION DATES	00/00/00	THROUGH	00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	52,886.07	381.00	OTHER LAB	1,071.00	0.00
MED/SURG SUPPLY	215,685.42	45.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,608.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,544.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	508.00	FEE SCHEDULE LAB	89,279.00	2,839.00
EKG/ECG	8,903.00	12,404.00	MRI SERVICES	0.00	0.00
IV THERAPY	117,096.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	545,164.00	3.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,971.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	36,531.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,120.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	31,885.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	507,922.39	80,594.32
RADIOLOGY THERAPEUTIC	65,816.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,071.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	912,858.06	2,523.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	749.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,462.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,673.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	365,615.00	42,856.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	35,667.01	518.00			
			TOTAL ANCILLARY	3,029,576.95	142,672.22
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,029,576.95	142,672.22

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: 08/24/2017
Run Time: 02:03:32
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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	10/01/15	THROUGH	09/30/16
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

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

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

PROVIDER NUMBER 000000118A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,305,759.98	ADJUSTMENTS	195,545.40
COVERED CHARGES	2,221,912.26	CONTRACTUAL ALLOW	1,500,250.10
NON-COVERD CHARGES	83,847.72	TOTAL MEDICAID LIAB	721,662.16
		LESS: COB	14,366.92
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	707,295.24

TOTAL NUMBER OF ADMISSIONS 128

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	331		0	218,130.60		130.80
ROUTINE NURSERY	25		0	15,708.70		764.50
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	356		0	233,839.30		895.30
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	92		0	108,833.60		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	92		0	108,833.60		0.00
TOTAL ACCOMODATIONS	448		0	342,672.90		895.30

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

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

Run Date: 08/24/2017
 Run Time: 02:06:39
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	421,777.96	1,685.32	OTHER LAB	7,543.40	0.00
MED/SURG SUPPLY	248,128.69	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	392,180.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	50,491.30	265.60	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	71,487.93	32,341.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	24,016.22	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	24,954.20	0.00	MRI SERVICES	19,869.50	0.00
IV THERAPY	10,221.20	30,364.20	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	120,573.91	4,660.40	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	31,107.20	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	104,438.22	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	7,483.10	1,807.80	CAST ROOM	0.00	0.00
EMERGENCY ROOM	98,863.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,911.90	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	17,068.90	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,244.70	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	181,367.20	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,053.93	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,617.40	11,828.10			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,264.50	0.00			
AUDIOLOGY	713.50	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	3,117.80	0.00			
			TOTAL ANCILLARY	1,879,239.36	82,952.42
			TOTAL ACCOMODATIONS	342,672.90	895.30
			TOTAL CHARGES	2,221,912.26	83,847.72

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,525.80	ADJUSTMENTS	0.00
COVERED CHARGES	18,663.35	CONTRACTUAL ALLOW	2,968.53
NON-COVERD CHARGES	862.45	TOTAL MEDICAID LIAB	15,694.82
		LESS: COB	15,694.82
		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	1,977.00		1.20
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3		0	1,977.00		1.20
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	3		0	1,977.00		1.20

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,900.77	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,031.58	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	641.40	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	861.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,940.80	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,171.80	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	16,686.35	861.25
			TOTAL ACCOMODATIONS	1,977.00	1.20
			TOTAL CHARGES	18,663.35	862.45

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,912,636.16	ADJUSTMENTS	1,810.48
COVERED CHARGES	1,624,144.53	CONTRACTUAL ALLOW	1,191,768.34
NON-COVERD CHARGES	288,491.63	TOTAL MEDICAID LIAB	432,376.19
		LESS: COB	202.77
		LESS: COPAYMENT	1,299.00
		REIMBURSEMENT	430,874.42
		ALL OTHER	386,776.25
		FEE SCHEDULE-LAB	44,098.17
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	1,432

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	131,884.79	4,435.93	OTHER LAB	20,141.80	0.00
MED/SURG SUPPLY	82,755.82	355.40	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,948.60	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	140,131.31	3,242.30	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	160,105.90	93,835.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,056.60	7,086.70	FEE SCHEDULE LAB	491,560.70	29,451.00
EKG/ECG	31,101.10	4,582.40	MRI SERVICES	56,863.50	4,526.70
IV THERAPY	7,488.80	25,056.70	PROFESSIONAL FEES	0.00	1,761.80
OPERATING ROOM	61,494.19	27,837.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,412.30	4,373.70	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	33,795.60	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	285,051.70	61,635.60	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,195.20	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,212.20	3,044.80	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	365.40	913.50	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	27,167.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	29,498.90	9,225.70			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,136.00	796.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,743.70	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	2,212.20			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	35,226.32	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,755.20	905.30			
			TOTAL ANCILLARY	1,624,144.53	287,226.93
			TOTAL ACCOMODATIONS	0.00	1,264.70
			TOTAL CHARGES	1,624,144.53	288,491.63

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

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,590.57	ADJUSTMENTS	0.00
COVERED CHARGES	6,487.30	CONTRACTUAL ALLOW	1,558.48
NON-COVERD CHARGES	2,103.27	TOTAL MEDICAID LIAB	4,928.82
		LESS: COB	4,923.42
		LESS: COPAYMENT	5.40
		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

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	198.40	91.67	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	371.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	193.90	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,055.20	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,177.20	87.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	129.50	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	1,252.80	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,414.30	CAST ROOM	0.00	0.00
EMERGENCY ROOM	238.60	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,487.30	2,103.27
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,487.30	2,103.27

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	203,051.57	ADJUSTMENTS	0.00
COVERED CHARGES	174,194.13	CONTRACTUAL ALLOW	159,300.43
NON-COVERD CHARGES	28,857.44	TOTAL MEDICAID LIAB	14,893.70
		LESS: COB	0.00
		LESS: COPAYMENT	672.00
		REIMBURSEMENT	14,221.70
		TOTAL NUMBER OF CLAIMS	298

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,948.63	444.54	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,099.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,809.20	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,804.00	6,689.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	39,627.50	2,645.80
EKG/ECG	714.80	178.70	MRI SERVICES	0.00	0.00
IV THERAPY	506.00	2,767.20	PROFESSIONAL FEES	0.00	761.60
OPERATING ROOM	0.00	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	84,586.10	12,718.30	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	0.00	2,652.30			
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	174,194.13	28,857.44
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	174,194.13	28,857.44

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,771.41	ADJUSTMENTS	0.00
COVERED CHARGES	971.72	CONTRACTUAL ALLOW	110.64
NON-COVERD CHARGES	799.69	TOTAL MEDICAID LIAB	861.08
		LESS: COB	861.08
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
 000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11.72	180.29	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	388.40	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	619.40
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	571.60	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	971.72	799.69
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	971.72	799.69

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: 08/24/2017
Run Time: 02:07:32
Page: 13

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,950.19	ADJUSTMENTS	0.00
COVERED CHARGES	18,193.95	CONTRACTUAL ALLOW	13,019.30
NON-COVERD CHARGES	1,756.24	TOTAL MEDICAID LIAB	5,174.65
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	5,165.65

TOTAL NUMBER OF CLAIMS 1

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,407.77	1,099.62	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,382.58	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	402.82	FEE SCHEDULE LAB	1,389.30	34.80
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	219.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,042.40	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	399.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,271.20	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	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	18,193.95	1,756.24
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,193.95	1,756.24

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: 08/24/2017
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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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
 Run Time: 03:58:24
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,716,417.91	ADJUSTMENTS	60,900.63
COVERED CHARGES	4,684,652.22	CONTRACTUAL ALLOW	2,903,019.51
NON-COVERD CHARGES	31,765.69	TOTAL MEDICAID LIAB	1,781,632.71
		LESS: COB	26,304.94
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,755,327.77

TOTAL NUMBER OF ADMISSIONS 207

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	417		0	289,815.00		17,568.21
ROUTINE NURSERY	30		0	17,857.50		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	447		0	307,672.50		17,568.21
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	572		0	769,341.66		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	572		0	769,341.66		0.00
TOTAL ACCOMODATIONS	1,019		0	1,077,014.16		17,568.21

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	431,388.60	0.00	OTHER LAB	21,221.89	0.00
MED/SURG SUPPLY	356,778.80	1,385.46	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	716,420.70	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	63,552.49	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	208,948.88	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	33,552.57	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	18,275.57	0.00	MRI SERVICES	22,013.80	0.00
IV THERAPY	29,657.66	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	110,893.20	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	13,231.05	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	225,024.23	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	146,922.19	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	16,290.84	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	8,266.79	0.00	INJECTABLE DRUGS	783,012.79	0.00
RADIOLOGY THERAPEUTIC	5,353.79	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	265.95	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,375.56	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	29,867.64	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	970.86	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	194,267.70	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	21,417.66	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	24,064.12	12,812.02			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	33,085.22	0.00			
AUDIOLOGY	991.20	0.00			
CARDIOLOGY	89,060.34	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	478.28	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	987.69	0.00			
			TOTAL ANCILLARY	3,607,638.06	14,197.48
			TOTAL ACCOMODATIONS	1,077,014.16	17,568.21
			TOTAL CHARGES	4,684,652.22	31,765.69

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

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	10/01/15	THROUGH	09/30/16
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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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,604,810.62	ADJUSTMENTS	164,797.17
COVERED CHARGES	5,329,014.31	CONTRACTUAL ALLOW	4,184,681.73
NON-COVERD CHARGES	275,796.31	TOTAL MEDICAID LIAB	1,144,332.58
		LESS: COB	6,856.48
		LESS: COPAYMENT	2,574.00
		REIMBURSEMENT	1,134,902.10
		ALL OTHER	881,050.31
		FEE SCHEDULE-LAB	211,391.40
		INJECTABLE DRUGS	42,460.39

TOTAL NUMBER OF CLAIMS 4,499

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	116,973.59	1,106.66	OTHER LAB	23,305.72	0.00
MED/SURG SUPPLY	208,293.17	8,995.40	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	62.53	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	228,433.94	484.12	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	793,186.50	57,173.67	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,022.12	729.48	FEE SCHEDULE LAB	1,366,675.56	50,253.95
EKG/ECG	60,213.85	605.82	MRI SERVICES	124,508.97	1,879.20
IV THERAPY	116,508.05	62.93	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	131,114.34	10,037.27	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,868.43	5,327.29	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	218.52	0.00	AMBULANCE	0.00	0.00
GI SERVICES	114,706.29	945.54	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,229,787.24	2,839.40	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	27,334.75	450.78	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	211,059.67	47,752.28
RADIOLOGY THERAPEUTIC	71,202.09	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	294.90	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,127.46	375.85	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,731.02	2,383.95	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	30,014.86	2,721.79
LITHOTRIPSY	9,548.17	0.00	NO CC/INVALID REV CODE	0.00	3,259.66
OTHER IMAGING SERVICE	173,888.08	18,531.52			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	48,484.71	18,725.26			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	64,660.40	39,028.04			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	38,813.46	1,461.05			
AMBULATORY SURGERY	1,054.74	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	74,270.16	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	45,713.55	602.87			
			TOTAL ANCILLARY	5,329,014.31	275,796.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,329,014.31	275,796.31

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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016151004543	05/23/16 - 05/23/16	06/06/16	0.00	1,629.83	0.00	0.00	0.00
615	2016182048638	06/16/16 - 06/16/16	07/04/16	0.00	1,629.83	0.00	0.00	0.00
TOTAL				0.00	3,259.66	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: 08/24/2017
Run Time: 03:58:50
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,871.05	ADJUSTMENTS	0.00
COVERED CHARGES	7,700.38	CONTRACTUAL ALLOW	2,647.46
NON-COVERD CHARGES	6,170.67	TOTAL MEDICAID LIAB	5,052.92
		LESS: COB	5,049.92
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 9

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57.20	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	181.31	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	939.10	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,257.69	3,539.97	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,842.00	750.71
EKG/ECG	201.94	100.97	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,938.13	417.66	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	304.87	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	375.82	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	978.14	985.54			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,700.38	6,170.67
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,700.38	6,170.67

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: 08/24/2017
Run Time: 03:58:51
Page: 9

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	158,199.39	ADJUSTMENTS	317.54
COVERED CHARGES	151,863.24	CONTRACTUAL ALLOW	137,206.96
NON-COVERD CHARGES	6,336.15	TOTAL MEDICAID LIAB	14,656.28
		LESS: COB	0.00
		LESS: COPAYMENT	451.80
		REIMBURSEMENT	14,204.48
		TOTAL NUMBER OF CLAIMS	262

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	868.48	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,574.59	26.22	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,665.56	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,792.38	4,335.22	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	25,705.02	708.61
EKG/ECG	1,211.64	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,070.82	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	100.52	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	87,289.09	279.44	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,758.87	73.70
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	3,926.79	812.44			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	151,863.24	6,336.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	151,863.24	6,336.15

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: 08/24/2017
Run Time: 03:58:52
Page: 11

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	10/01/15	THROUGH	09/30/16
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: 08/24/2017
Run Time: 03:58:53
Page: 12

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	90,440.67	ADJUSTMENTS	5,471.05
COVERED CHARGES	90,258.29	CONTRACTUAL ALLOW	73,827.14
NON-COVERD CHARGES	182.38	TOTAL MEDICAID LIAB	16,431.15
		LESS: COB	0.00
		LESS: COPAYMENT	114.00
		REIMBURSEMENT	16,317.15

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,323.43	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,221.87	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	31,367.97	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	257.99	13.01
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,142.52	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	450.78	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	664.63	169.37
RADIOLOGY THERAPEUTIC	32,275.18	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	16,553.92	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	90,258.29	182.38
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	90,258.29	182.38

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: 08/24/2017
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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	10/01/15	THROUGH	09/30/16
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: 08/24/2017
 Run Time: 03:54:23
 Page: 1

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,390,385.87	ADJUSTMENTS	24,622.13
COVERED CHARGES	3,086,515.22	CONTRACTUAL ALLOW	2,057,345.18
NON-COVERD CHARGES	303,870.65	TOTAL MEDICAID LIAB	1,029,170.04
		LESS: COB	10,473.06
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,018,696.98

TOTAL NUMBER OF ADMISSIONS 150

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	637		64	382,200.00		290,237.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	637		64	382,200.00		290,237.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	76		0	110,884.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	76		0	110,884.00		0.00
TOTAL ACCOMODATIONS	713		64	493,084.00		290,237.00

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	451,926.36	0.00	OTHER LAB	13,662.78	0.00
MED/SURG SUPPLY	118,060.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	317,289.40	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	35,479.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	114,599.00	1,334.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	48,993.95	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	25,284.00	0.00	MRI SERVICES	3,483.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	134,078.77	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	302,751.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,577.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	109,726.94	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	27,562.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,943.00	0.00	INJECTABLE DRUGS	12,293.87	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,071.79	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	10,283.76	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	758,951.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,222.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	16,388.04	10,780.65			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,017.00	1,519.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	46,002.06	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,785.00	0.00			
			TOTAL ANCILLARY	2,593,431.22	13,633.65
			TOTAL ACCOMODATIONS	493,084.00	290,237.00
			TOTAL CHARGES	3,086,515.22	303,870.65

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

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

Run Date: 08/24/2017
Run Time: 03:54:25
Page: 3

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	01/01/16	THROUGH	12/31/16
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: 08/24/2017
Run Time: 03:54:26
Page: 4

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,201,727.77	ADJUSTMENTS	17,953.05
COVERED CHARGES	1,937,409.26	CONTRACTUAL ALLOW	1,565,718.72
NON-COVERD CHARGES	264,318.51	TOTAL MEDICAID LIAB	371,690.54
		LESS: COB	70.00
		LESS: COPAYMENT	1,343.56
		REIMBURSEMENT	370,276.98
		ALL OTHER	319,309.39
		FEE SCHEDULE-LAB	46,657.71
		INJECTABLE DRUGS	4,309.88
		TOTAL NUMBER OF CLAIMS	1,636

SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER
 000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,502.43	23,373.23	OTHER LAB	17,558.78	0.00
MED/SURG SUPPLY	67,471.00	6,222.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	105,216.89	8,024.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	209,440.00	24,498.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,976.87	2,783.00	FEE SCHEDULE LAB	423,169.82	30,352.82
EKG/ECG	34,701.00	0.00	MRI SERVICES	64,578.00	2,039.00
IV THERAPY	112,752.31	2,106.44	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	180,169.50	29,976.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	29,371.90	5,902.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	23,609.00	1,694.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	418,711.99	4,706.26	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	32,036.00	16,096.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	61,757.22	21,314.25
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	984.87	328.38	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,984.17	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	8,050.00	64,267.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	38,065.03	1,727.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,193.40	1,437.42			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,610.29	8,409.80			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	31,938.96	7,077.24			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	24,544.00	0.00			
			TOTAL ANCILLARY	1,937,409.26	264,318.51
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,937,409.26	264,318.51

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: 08/24/2017
Run Time: 03:54:37
Page: 6

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,920.46	ADJUSTMENTS	0.00
COVERED CHARGES	6,152.46	CONTRACTUAL ALLOW	2,098.31
NON-COVERD CHARGES	2,768.00	TOTAL MEDICAID LIAB	4,054.15
		LESS: COB	4,054.15
		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

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	56.07	0.00	OTHER LAB	711.00	0.00
MED/SURG SUPPLY	34.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	400.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,722.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,305.00	46.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	775.86	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	387.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,379.39	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	104.14	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,152.46	2,768.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,152.46	2,768.00

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: 08/24/2017
Run Time: 03:54:37
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	216,950.81	ADJUSTMENTS	0.00
COVERED CHARGES	206,061.18	CONTRACTUAL ALLOW	191,516.78
NON-COVERD CHARGES	10,889.63	TOTAL MEDICAID LIAB	14,544.40
		LESS: COB	0.00
		LESS: COPAYMENT	535.82
		REIMBURSEMENT	14,008.58
		TOTAL NUMBER OF CLAIMS	260

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,219.60	93.65	OTHER LAB	560.00	0.00
MED/SURG SUPPLY	580.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,606.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,105.00	5,444.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	30,484.37	2,557.73
EKG/ECG	2,193.00	0.00	MRI SERVICES	3,673.00	0.00
IV THERAPY	13,093.31	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,261.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	121,474.16	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	5,445.74	329.25
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	2,366.00	2,465.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	206,061.18	10,889.63
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	206,061.18	10,889.63

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: 08/24/2017
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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	01/01/16	THROUGH	12/31/16
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

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	01/01/16	THROUGH	12/31/16
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

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	01/01/16	THROUGH	12/31/16
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	234,815.50	ADJUSTMENTS	0.00
COVERED CHARGES	208,102.00	CONTRACTUAL ALLOW	132,767.85
NON-COVERD CHARGES	26,713.50	TOTAL MEDICAID LIAB	75,334.15
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	75,334.15

TOTAL NUMBER OF ADMISSIONS 14

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	87		0	36,405.00		26,713.50
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	87		0	36,405.00		26,713.50
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	87		0	36,405.00		26,713.50

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63,079.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,678.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	27,462.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,113.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	31,750.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,945.25	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,204.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,413.75	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	8,101.25	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	3,554.25	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	15,575.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	222.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	256.50	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	794.25	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	1,312.25	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	234.00	0.00			
			TOTAL ANCILLARY	171,697.00	0.00
			TOTAL ACCOMODATIONS	36,405.00	26,713.50
			TOTAL CHARGES	208,102.00	26,713.50

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 10/01/15 THROUGH 09/30/16
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: 08/24/2017
Run Time: 04:05:09
Page: 4

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

PROVIDER NUMBER
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	924,661.92	ADJUSTMENTS	32,386.57
COVERED CHARGES	785,246.67	CONTRACTUAL ALLOW	511,649.67
NON-COVERD CHARGES	139,415.25	TOTAL MEDICAID LIAB	273,597.00
		LESS: COB	999.70
		LESS: COPAYMENT	846.00
		REIMBURSEMENT	271,751.30
		ALL OTHER	241,832.38
		FEE SCHEDULE-LAB	28,785.18
		INJECTABLE DRUGS	1,133.74

TOTAL NUMBER OF CLAIMS 1,065

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: 08/24/2017
 Run Time: 04:05:09
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	43,576.67	0.00	OTHER LAB	16,068.25	475.00
MED/SURG SUPPLY	15,458.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	83,385.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	122,533.75	111,652.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	156,728.50	17,361.50
EKG/ECG	12,719.50	0.00	MRI SERVICES	2,174.25	3,824.00
IV THERAPY	46,758.75	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	187.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	169,887.25	136.50	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	14,879.00	292.50
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	171.00	865.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	93.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	25,593.00	4,238.75			
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	3,936.75	569.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	66,027.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,068.50	0.00			
			TOTAL ANCILLARY	785,246.67	139,415.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	785,246.67	139,415.25

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,557.88	ADJUSTMENTS	0.00
COVERED CHARGES	9,832.38	CONTRACTUAL ALLOW	2,725.88
NON-COVERD CHARGES	2,725.50	TOTAL MEDICAID LIAB	7,106.50
		LESS: COB	7,103.50
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5

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

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

PROVIDER NUMBER
 000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24.88	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	225.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	165.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,878.00	2,700.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	394.50	25.50
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	1,442.25	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	1,702.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,832.38	2,725.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,832.38	2,725.50

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: 08/24/2017
Run Time: 04:05:14
Page: 8

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

PROVIDER NUMBER
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	56,252.71	ADJUSTMENTS	105.88
COVERED CHARGES	48,181.46	CONTRACTUAL ALLOW	41,300.84
NON-COVERD CHARGES	8,071.25	TOTAL MEDICAID LIAB	6,880.62
		LESS: COB	0.00
		LESS: COPAYMENT	237.00
		REIMBURSEMENT	6,643.62
		TOTAL NUMBER OF CLAIMS	123

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
 000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,262.96	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	763.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,395.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	6,942.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,706.00	1,128.75
EKG/ECG	172.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,126.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	29,478.75	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	1,276.75	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	48,181.46	8,071.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	48,181.46	8,071.25

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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	978.02	ADJUSTMENTS	0.00
COVERED CHARGES	978.02	CONTRACTUAL ALLOW	788.67
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	189.35
		LESS: COB	189.35
		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: 08/24/2017
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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2.77	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	75.75	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	584.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	978.02	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	978.02	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

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

PROVIDER NUMBER
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,882.37	ADJUSTMENTS	5,545.23
COVERED CHARGES	25,682.12	CONTRACTUAL ALLOW	20,136.89
NON-COVERD CHARGES	200.25	TOTAL MEDICAID LIAB	5,545.23
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,545.23

TOTAL NUMBER OF CLAIMS 1

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

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

PROVIDER NUMBER
 000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,303.62	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	201.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	762.25	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	1,110.75	200.25
EKG/ECG	172.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	18,564.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,276.00	0.00			
			TOTAL ANCILLARY	25,682.12	200.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,682.12	200.25

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: 08/24/2017
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Page: 14

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER
000000173A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/15	THROUGH	09/30/16
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: 08/24/2017
 Run Time: 02:08:58
 Page: 1

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 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	153,075.19	ADJUSTMENTS	31,470.77
COVERED CHARGES	147,247.39	CONTRACTUAL ALLOW	41,352.14
NON-COVERD CHARGES	5,827.80	TOTAL MEDICAID LIAB	105,895.25
		LESS: COB	623.92
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	105,271.33
TOTAL NUMBER OF ADMISSIONS			23

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	61		0	29,585.00		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	61		0	29,585.00		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	61		0	29,585.00		0.00

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 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,082.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,269.27	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	27,463.38	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,894.65	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,863.40	3,440.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	244.75	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,175.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,552.20	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,669.74	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,523.80	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	314.60	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,690.50	2,387.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	780.85	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	5,138.00	0.00			
			TOTAL ANCILLARY	117,662.39	5,827.80
			TOTAL ACCOMODATIONS	29,585.00	0.00
			TOTAL CHARGES	147,247.39	5,827.80

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

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

Run Date: 08/24/2017
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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	04/01/15	THROUGH	03/31/16
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: 08/24/2017
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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 04/01/15 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	586,561.34	ADJUSTMENTS	29,550.75
COVERED CHARGES	554,036.30	CONTRACTUAL ALLOW	219,073.17
NON-COVERD CHARGES	32,525.04	TOTAL MEDICAID LIAB	334,963.13
		LESS: COB	1,379.60
		LESS: COPAYMENT	597.00
		REIMBURSEMENT	332,986.53
		ALL OTHER	296,353.81
		FEE SCHEDULE-LAB	26,147.11
		INJECTABLE DRUGS	10,485.61

TOTAL NUMBER OF CLAIMS 730

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: 08/24/2017
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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 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,899.76	758.06	OTHER LAB	39,420.36	0.00
MED/SURG SUPPLY	18,668.22	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,172.90	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	34,908.40	1,464.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	44,361.95	6,660.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	181,406.08	9,590.03
EKG/ECG	12,207.10	955.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,462.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	236.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,670.80	688.60	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	137,197.98	2,532.50	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	21,720.90	5,046.45
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	145.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,916.85	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,389.60	2,729.35			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,561.70	780.85			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	21,008.10	0.00			
			TOTAL ANCILLARY	554,036.30	32,525.04
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	554,036.30	32,525.04

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: 08/24/2017
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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 04/01/15 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,731.18	ADJUSTMENTS	0.00
COVERED CHARGES	1,439.28	CONTRACTUAL ALLOW	89.81
NON-COVERD CHARGES	1,291.90	TOTAL MEDICAID LIAB	1,349.47
		LESS: COB	1,346.47
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

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 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 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	506.00	0.00
MED/SURG SUPPLY	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	933.28	511.05
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	780.85			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,439.28	1,291.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,439.28	1,291.90

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: 08/24/2017
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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 04/01/15 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,608.03	ADJUSTMENTS	0.00
COVERED CHARGES	28,208.58	CONTRACTUAL ALLOW	24,358.58
NON-COVERD CHARGES	1,399.45	TOTAL MEDICAID LIAB	3,850.00
		LESS: COB	0.00
		LESS: COPAYMENT	159.00
		REIMBURSEMENT	3,691.00
		TOTAL NUMBER OF CLAIMS	77

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 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	630.58	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	297.45	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,417.40	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,330.40	805.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,093.35	480.95
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	541.20	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,116.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,656.70	113.50
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	28,208.58	1,399.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	28,208.58	1,399.45

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

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 04/01/15 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,777.95	ADJUSTMENTS	0.00
COVERED CHARGES	1,764.15	CONTRACTUAL ALLOW	1,761.15
NON-COVERD CHARGES	13.80	TOTAL MEDICAID LIAB	3.00
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
 000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	195.90	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	99.65	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	165.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	468.15	13.80
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	704.50	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	130.95	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,764.15	13.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,764.15	13.80

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

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	04/01/15	THROUGH	03/31/16
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: 08/24/2017
Run Time: 02:09:28
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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	04/01/15	THROUGH	03/31/16
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: 08/24/2017
 Run Time: 02:09:36
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	109,347.00	ADJUSTMENTS	0.00
COVERED CHARGES	108,495.00	CONTRACTUAL ALLOW	54,911.54
NON-COVERD CHARGES	852.00	TOTAL MEDICAID LIAB	53,583.46
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	53,583.46

TOTAL NUMBER OF ADMISSIONS 9

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	32		0	19,176.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	32		0	19,176.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	32		0	19,176.00		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: 08/24/2017
 Run Time: 02:09:36
 Page: 2

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,295.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,624.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	28,732.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,691.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,379.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,701.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,274.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,982.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,598.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	652.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	836.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	978.00	852.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,577.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	89,319.00	852.00
			TOTAL ACCOMODATIONS	19,176.00	0.00
			TOTAL CHARGES	108,495.00	852.00

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

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	10/01/15	THROUGH	09/30/16
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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,424,719.20	ADJUSTMENTS	13,564.06
COVERED CHARGES	1,344,223.18	CONTRACTUAL ALLOW	999,092.46
NON-COVERD CHARGES	80,496.02	TOTAL MEDICAID LIAB	345,130.72
		LESS: COB	63.18
		LESS: COPAYMENT	1,092.00
		REIMBURSEMENT	343,975.54
		ALL OTHER	283,545.28
		FEE SCHEDULE-LAB	55,949.24
		INJECTABLE DRUGS	4,481.02
		TOTAL NUMBER OF CLAIMS	1,640

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	179,860.80	0.00	OTHER LAB	4,532.00	0.00
MED/SURG SUPPLY	14,862.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	100.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	129,443.00	517.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	136,576.00	18,734.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	40,770.00	24,713.02	FEE SCHEDULE LAB	444,674.38	20,353.00
EKG/ECG	17,207.00	0.00	MRI SERVICES	3,171.00	0.00
IV THERAPY	55,083.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	44,167.00	1,904.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	191,743.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	32,670.00	3,047.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,647.00	3,341.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	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	69.00
OTHER IMAGING SERVICE	22,631.00	580.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	978.00	3,171.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	18,924.00	3,736.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	284.00	0.00			
			TOTAL ANCILLARY	1,344,223.18	80,496.02
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,344,223.18	80,496.02

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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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016259008269	08/29/16 - 08/29/16	09/19/16	0.00	69.00	0.00	0.00	0.00
TOTAL				0.00	69.00	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

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,312.00	ADJUSTMENTS	0.00
COVERED CHARGES	5,273.00	CONTRACTUAL ALLOW	1,721.18
NON-COVERD CHARGES	39.00	TOTAL MEDICAID LIAB	3,551.82
		LESS: COB	3,548.82
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 6

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 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	116.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	661.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,944.00	26.00
EKG/ECG	177.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,141.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	234.00	13.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	5,273.00	39.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,273.00	39.00

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	55,625.00	ADJUSTMENTS	50.00
COVERED CHARGES	52,298.00	CONTRACTUAL ALLOW	48,198.00
NON-COVERD CHARGES	3,327.00	TOTAL MEDICAID LIAB	4,100.00
		LESS: COB	0.00
		LESS: COPAYMENT	60.00
		REIMBURSEMENT	4,040.00
		TOTAL NUMBER OF CLAIMS	82

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	110.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	818.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,506.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,885.00	1,960.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,613.00	937.00
EKG/ECG	177.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,397.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	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	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,289.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,048.00	430.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	311.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	52,298.00	3,327.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	52,298.00	3,327.00

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,076.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,076.00	CONTRACTUAL ALLOW	618.07
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	457.93
		LESS: COB	457.93
		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

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 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	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	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	546.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,076.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,076.00	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

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	374,595.00	ADJUSTMENTS	0.00
COVERED CHARGES	370,830.00	CONTRACTUAL ALLOW	312,475.32
NON-COVERD CHARGES	3,765.00	TOTAL MEDICAID LIAB	58,354.68
		LESS: COB	0.00
		LESS: COPAYMENT	42.00
		REIMBURSEMENT	58,312.68

TOTAL NUMBER OF CLAIMS 12

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	227,673.00	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	1,120.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	59,011.00	1,170.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	82,135.00	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	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.	891.00	2,595.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	370,830.00	3,765.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	370,830.00	3,765.00

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: 08/24/2017
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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	10/01/15	THROUGH	09/30/16
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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,708,727.22	ADJUSTMENTS	661,848.61
COVERED CHARGES	24,395,753.27	CONTRACTUAL ALLOW	19,379,495.97
NON-COVERD CHARGES	312,973.95	TOTAL MEDICAID LIAB	5,016,257.30
		LESS: COB	36,924.75
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,979,332.55

TOTAL NUMBER OF ADMISSIONS 687

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,085		0	608,035.00		122,522.52
ROUTINE NURSERY	328		0	184,429.08		32,766.31
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,413		0	792,464.08		155,288.83
SPECIAL CARE SERVICES						
CCU	183		0	228,882.94		0.00
ICU	984		0	1,086,213.92		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,167		0	1,315,096.86		0.00
TOTAL ACCOMODATIONS	2,580		0	2,107,560.94		155,288.83

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

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

Run Date: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,032,382.75	0.00	OTHER LAB	75,266.16	0.00
MED/SURG SUPPLY	3,573,065.27	3,021.24	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,171,921.45	0.00	EDUCATION & TRAINING	11,162.07	0.00
RADIOLOGY-DIAGNOSTIC	451,105.02	14,783.55	OTHER THERAPEUTIC SVC	0.00	12,630.03
CT SCAN	1,214,355.67	3,646.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	172,324.29	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	70,251.29	0.00	MRI SERVICES	282,002.57	0.00
IV THERAPY	8,611.65	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,202,697.16	0.00	DURABLE MED. EQUIP.	0.00	104.39
LABOR/DELIVERY ROOM	373,365.65	1,425.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,202,959.79	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	680,046.93	0.00	AMBULANCE	0.00	0.00
GI SERVICES	224,431.60	66,681.26	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,548,609.56	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	122,453.64	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	117,698.80	0.00	INJECTABLE DRUGS	468,198.30	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,529.40	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	18,046.43	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	85,041.30	4,297.80	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,642.06	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,047,994.57	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	16,230.96
OTHER IMAGING SERVICE	100,738.13	5,960.51			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	130,311.10	24,217.12			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	45,748.41	4,687.26			
AUDIOLOGY	16,420.11	0.00			
CARDIOLOGY	749,541.66	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	41,718.88	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	38,550.66	0.00			
			TOTAL ANCILLARY	22,288,192.33	157,685.12
			TOTAL ACCOMODATIONS	2,107,560.94	155,288.83
			TOTAL CHARGES	24,395,753.27	312,973.95

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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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015324058975	11/04/15 - 11/07/15	11/23/15	0.00	2,958.89	0.00	0.00	0.00
615	5916104001808	03/07/16 - 03/16/16	04/18/16	0.00	3,136.42	0.00	0.00	0.00
615	2016112048428	04/06/16 - 04/08/16	04/25/16	0.00	6,999.23	0.00	0.00	0.00
615	2216299001283	02/28/16 - 02/29/16	10/31/16	0.00	3,136.42	0.00	0.00	0.00
TOTAL				0.00	16,230.96	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: 08/24/2017
 Run Time: 02:48:58
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	167,857.13	ADJUSTMENTS	0.00
COVERED CHARGES	167,042.38	CONTRACTUAL ALLOW	135,227.23
NON-COVERD CHARGES	814.75	TOTAL MEDICAID LIAB	31,815.15
		LESS: COB	31,815.15
		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	7		0	3,908.00		324.39
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	7		0	3,908.00		324.39
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	9		0	9,553.63		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	9		0	9,553.63		0.00
TOTAL ACCOMODATIONS	16		0	13,461.63		324.39

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,432.35	0.00	OTHER LAB	627.53	0.00
MED/SURG SUPPLY	31,909.48	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	15,967.29	0.00	EDUCATION & TRAINING	240.38	0.00
RADIOLOGY-DIAGNOSTIC	1,045.06	0.00	OTHER THERAPEUTIC SVC	0.00	184.95
CT SCAN	4,352.16	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	180.84	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	29,264.22	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	20,660.26	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,567.90	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,556.15	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,045.90	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,000.95	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	769.26	0.00	INJECTABLE DRUGS	14,274.23	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	249.66	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	679.65	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,757.48	305.41			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	153,580.75	490.36
			TOTAL ACCOMODATIONS	13,461.63	324.39
			TOTAL CHARGES	167,042.38	814.75

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

Run Date: 08/24/2017
Run Time: 02:49:00
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	28,616,689.03	ADJUSTMENTS	601,796.59
COVERED CHARGES	25,845,487.21	CONTRACTUAL ALLOW	23,614,175.09
NON-COVERD CHARGES	2,771,201.82	TOTAL MEDICAID LIAB	2,231,312.12
		LESS: COB	1,446.07
		LESS: COPAYMENT	4,491.95
		REIMBURSEMENT	2,225,374.10
		ALL OTHER	2,039,193.84
		FEE SCHEDULE-LAB	156,917.77
		INJECTABLE DRUGS	29,262.49

TOTAL NUMBER OF CLAIMS 5,163

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	164,914.23	180,864.72	OTHER LAB	498,763.76	19,818.63
MED/SURG SUPPLY	2,788,253.63	17,088.93	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	238.30	133.80
RADIOLOGY-DIAGNOSTIC	1,076,403.23	41,667.74	OTHER THERAPEUTIC SVC	0.00	84,364.17
CT SCAN	2,297,597.60	235,099.51	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,152.42	FEE SCHEDULE LAB	3,058,351.73	169,499.32
EKG/ECG	102,155.76	7,183.68	MRI SERVICES	590,827.61	31,057.35
IV THERAPY	28,442.63	2,015.57	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,259,656.64	600,486.39	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	463,682.68	196,665.28	FREE STANDING CLINIC	9,611.37	0.00
ANESTHESIA	854,705.07	16,527.03	AMBULANCE	0.00	0.00
GI SERVICES	489,277.07	44,303.76	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,027,850.98	129,035.77	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	353,101.58	4,479.20	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	877,870.81	168,865.02
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	3,362.18	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,095.75	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	66,361.37	21,135.64	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	53,088.70	436,484.71
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	18,202.00
OTHER IMAGING SERVICE	557,821.45	66,689.55			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	25,440.69	4,545.34			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	117,287.46	43,860.33			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,356,470.11	210,595.10			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	135,952.35	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	591,360.40	12,031.91			
			TOTAL ANCILLARY	25,845,487.21	2,770,310.82
			TOTAL ACCOMODATIONS	0.00	891.00
			TOTAL CHARGES	25,845,487.21	2,771,201.82

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: 08/24/2017
Run Time: 02:49:00
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
436	5915356000083	12/11/15 - 12/11/15	12/28/15	0.00	155.20	0.00	0.00	0.00
614	5916175001058	06/02/16 - 06/02/16	06/27/16	0.00	8,207.40	0.00	0.00	0.00
614	2016214012888	04/01/16 - 04/01/16	08/08/16	0.00	8,207.40	0.00	0.00	0.00
614	2016299037470	09/08/16 - 09/08/16	10/31/16	0.00	1,632.00	0.00	0.00	0.00
TOTAL				0.00	18,202.00	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

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	867,648.39	ADJUSTMENTS	0.00
COVERED CHARGES	727,330.38	CONTRACTUAL ALLOW	402,365.74
NON-COVERD CHARGES	140,318.01	TOTAL MEDICAID LIAB	324,964.64
		LESS: COB	324,931.15
		LESS: COPAYMENT	33.49
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 132

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,605.93	12,678.27	OTHER LAB	15,480.46	0.00
MED/SURG SUPPLY	121,452.87	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,070.45	1,410.00	OTHER THERAPEUTIC SVC	0.00	1,293.83
CT SCAN	23,596.68	21,267.03	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	95,121.83	3,905.86
EKG/ECG	1,446.88	0.00	MRI SERVICES	1,632.39	18,883.25
IV THERAPY	996.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	82,445.40	27,043.37	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,788.92	1,775.68	FREE STANDING CLINIC	456.60	0.00
ANESTHESIA	41,400.67	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	4,202.76	CAST ROOM	0.00	0.00
EMERGENCY ROOM	226,896.59	4,525.53	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,333.69	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	29,049.69	5,129.85
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	117.03	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	2,008.30
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	14,654.07	11,970.28			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,749.77	706.18			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	23,203.77			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	8,739.03	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	15,411.96	197.02			
			TOTAL ANCILLARY	727,330.38	140,318.01
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	727,330.38	140,318.01

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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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,766,555.22	ADJUSTMENTS	1,673.46
COVERED CHARGES	1,713,996.78	CONTRACTUAL ALLOW	1,682,446.62
NON-COVERD CHARGES	52,558.44	TOTAL MEDICAID LIAB	31,550.16
		LESS: COB	0.00
		LESS: COPAYMENT	895.78
		REIMBURSEMENT	30,654.38
		TOTAL NUMBER OF CLAIMS	564

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

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,335.99	12,068.21	OTHER LAB	20,314.03	3,392.47
MED/SURG SUPPLY	68,094.46	2,128.72	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	63,782.15	989.13	OTHER THERAPEUTIC SVC	0.00	2,923.98
CT SCAN	125,996.36	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	197,430.76	6,965.86
EKG/ECG	3,617.92	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	69.66	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,129.98	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,426.68	640.76	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,745.01	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,739.91	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,104,493.32	7,658.67	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,000.95	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	43,597.26	4,776.76
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	43,451.68	9,544.55			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,194.04	1,469.33			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,576.62	0.00			
			TOTAL ANCILLARY	1,713,996.78	52,558.44
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,713,996.78	52,558.44

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

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	78,132.15	ADJUSTMENTS	0.00
COVERED CHARGES	74,869.31	CONTRACTUAL ALLOW	54,428.65
NON-COVERD CHARGES	3,262.84	TOTAL MEDICAID LIAB	20,440.66
		LESS: COB	20,419.66
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	16

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	650.41	241.02	OTHER LAB	2,305.14	0.00
MED/SURG SUPPLY	3,183.63	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,631.96	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,870.76	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,983.50	47.12
EKG/ECG	181.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	37,975.49	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,622.04	21.45
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	4,465.38	2,953.25			
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	74,869.31	3,262.84
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	74,869.31	3,262.84

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

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,743,060.61	ADJUSTMENTS	88,656.73
COVERED CHARGES	2,528,697.73	CONTRACTUAL ALLOW	2,362,340.83
NON-COVERD CHARGES	214,362.88	TOTAL MEDICAID LIAB	166,356.90
		LESS: COB	0.00
		LESS: COPAYMENT	125.94
		REIMBURSEMENT	166,230.96
		TOTAL NUMBER OF CLAIMS	30

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,785.59	21,618.20	OTHER LAB	2,305.14	0.00
MED/SURG SUPPLY	680,820.07	157.09	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,361.07	0.00	OTHER THERAPEUTIC SVC	0.00	838.76
CT SCAN	6,363.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,423.86	FEE SCHEDULE LAB	41,526.49	1,097.90
EKG/ECG	723.36	904.20	MRI SERVICES	4,885.38	0.00
IV THERAPY	216.80	2,397.62	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,160,604.26	17,018.99	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,331.76	443.92	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	158,265.91	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,154.85	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	43,470.78	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	53,418.04	13,183.64
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	213,270.06	152,469.98
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,734.94	2,808.72			
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	115,740.13	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,720.10	0.00			
			TOTAL ANCILLARY	2,528,697.73	214,362.88
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,528,697.73	214,362.88

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: 08/24/2017
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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	10/01/15	THROUGH	09/30/16
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: 08/24/2017
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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 06/01/15 THROUGH 05/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	177,045.20	ADJUSTMENTS	16,360.87
COVERED CHARGES	176,533.20	CONTRACTUAL ALLOW	62,027.35
NON-COVERD CHARGES	512.00	TOTAL MEDICAID LIAB	114,505.85
		LESS: COB	1,618.60
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	112,887.25

TOTAL NUMBER OF ADMISSIONS 18

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	42		0	23,680.00		512.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	42		0	23,680.00		512.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	42		0	23,680.00		512.00

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 06/01/15 THROUGH 05/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,231.14	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	15,107.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	30,214.00	0.00	EDUCATION & TRAINING	268.00	0.00
RADIOLOGY-DIAGNOSTIC	5,325.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,491.33	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	226.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	5,768.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,220.50	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	17,127.50	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	17,376.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18,808.13	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	606.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,876.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,206.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	152,853.20	0.00
			TOTAL ACCOMODATIONS	23,680.00	512.00
			TOTAL CHARGES	176,533.20	512.00

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

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 06/01/15 THROUGH 05/31/16
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: 08/24/2017
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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 06/01/15 THROUGH 05/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,137,217.43	ADJUSTMENTS	34,898.01
COVERED CHARGES	1,015,894.39	CONTRACTUAL ALLOW	702,671.54
NON-COVERD CHARGES	121,323.04	TOTAL MEDICAID LIAB	313,222.85
		LESS: COB	1,073.34
		LESS: COPAYMENT	651.00
		REIMBURSEMENT	311,498.51
		ALL OTHER	286,751.36
		FEE SCHEDULE-LAB	24,260.76
		INJECTABLE DRUGS	486.39
		TOTAL NUMBER OF CLAIMS	1,044

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: 08/24/2017
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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 06/01/15 THROUGH 05/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,561.40	7,406.50	OTHER LAB	1,877.50	0.00
MED/SURG SUPPLY	21,113.99	14,294.54	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,600.00	EDUCATION & TRAINING	0.00	268.00
RADIOLOGY-DIAGNOSTIC	60,083.00	3,247.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	93,392.01	12,709.90	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	164,769.75	21,313.50
EKG/ECG	15,861.00	500.00	MRI SERVICES	14,156.73	0.00
IV THERAPY	52,945.25	7,587.75	PROFESSIONAL FEES	0.00	20.00
OPERATING ROOM	17,984.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	15,538.64	8,350.85	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,428.80	0.00	AMBULANCE	0.00	0.00
GI SERVICES	15,730.75	4,816.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	382,809.50	24,941.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,873.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,939.25	7,016.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,326.51	512.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,056.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,678.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	53,779.50	893.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	466.75	651.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,652.00	1,987.25			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,587.53	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	29,339.53	2,150.00			
			TOTAL ANCILLARY	1,015,894.39	121,323.04
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,015,894.39	121,323.04

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

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 06/01/15 THROUGH 05/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,996.35	ADJUSTMENTS	0.00
COVERED CHARGES	1,011.20	CONTRACTUAL ALLOW	-12.68
NON-COVERD CHARGES	985.15	TOTAL MEDICAID LIAB	1,023.88
		LESS: COB	1,022.63
		LESS: COPAYMENT	1.25
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3

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

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 06/01/15 THROUGH 05/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29.00	56.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	24.70	53.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	34.25
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	235.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	841.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	722.50	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	1,011.20	985.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,011.20	985.15

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: 08/24/2017
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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 06/01/15 THROUGH 05/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	96,851.58	ADJUSTMENTS	0.00
COVERED CHARGES	93,587.07	CONTRACTUAL ALLOW	85,755.47
NON-COVERD CHARGES	3,264.51	TOTAL MEDICAID LIAB	7,831.60
		LESS: COB	0.00
		LESS: COPAYMENT	257.55
		REIMBURSEMENT	7,574.05
		TOTAL NUMBER OF CLAIMS	140

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 06/01/15 THROUGH 05/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,642.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,072.21	230.65	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,025.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,440.86	1,608.86	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,593.00	868.00
EKG/ECG	850.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,835.25	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	163.50	105.25	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	67,151.25	162.75	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	359.75	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	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,029.75	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	424.00	0.00			
			TOTAL ANCILLARY	93,587.07	3,264.51
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	93,587.07	3,264.51

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

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 06/01/15 THROUGH 05/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	460.60	ADJUSTMENTS	0.00
COVERED CHARGES	458.30	CONTRACTUAL ALLOW	297.70
NON-COVERD CHARGES	2.30	TOTAL MEDICAID LIAB	160.60
		LESS: COB	160.60
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
 000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 06/01/15 THROUGH 05/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3.30	2.30	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	451.50	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	458.30	2.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	458.30	2.30

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

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

Run Date: 08/24/2017
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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	06/01/15	THROUGH	05/31/16
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: 08/24/2017
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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER
000000283A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	06/01/15	THROUGH	05/31/16
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: 08/24/2017
 Run Time: 02:46:41
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	91,372,776.79	ADJUSTMENTS	5,931,251.07
COVERED CHARGES	84,969,698.99	CONTRACTUAL ALLOW	60,362,783.53
NON-COVERD CHARGES	6,403,077.80	TOTAL MEDICAID LIAB	24,606,915.46
		LESS: COB	429,643.51
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	24,177,271.95

TOTAL NUMBER OF ADMISSIONS 3,579

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	8,768	23	12,129,587.00	4,731,421.00
ROUTINE NURSERY	4,434	6	6,860,676.00	44,377.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	1,630.00
TOTAL ROUTINE	13,202	29	18,990,263.00	4,777,428.00
SPECIAL CARE SERVICES				
CCU	117	0	462,794.00	0.00
ICU	2,166	0	7,143,145.00	136,470.00
NICU	715	0	2,592,612.00	32,100.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2,998	0	10,198,551.00	168,570.00
TOTAL ACCOMODATIONS	16,200	29	29,188,814.00	4,945,998.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,556,351.73	100,716.30	OTHER LAB	602,433.00	11,025.00
MED/SURG SUPPLY	468,689.50	63,137.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,093,052.00	112,330.50	EDUCATION & TRAINING	11,354.00	284.00
RADIOLOGY-DIAGNOSTIC	2,619,841.50	25,921.00	OTHER THERAPEUTIC SVC	0.00	23,659.00
CT SCAN	4,287,352.00	187,719.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	456,517.80	55,562.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	628,284.00	2,388.00	MRI SERVICES	880,381.00	0.00
IV THERAPY	873,903.00	7,692.00	PROFESSIONAL FEES	0.00	86.00
OPERATING ROOM	7,954,267.50	150,807.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	574,919.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,477,885.00	80,573.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,521,399.50	33,996.00	AMBULANCE	0.00	0.00
GI SERVICES	352,710.00	6,926.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,584,934.00	3,347.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,427,505.00	7,978.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	478,504.00	3,354.50	INJECTABLE DRUGS	4,229,400.15	75,403.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	175,899.00	16,181.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	114,510.91	3,122.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,017,275.00	42,546.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,768.00	2,107.00	TRAUMA RESPONSE	0.00	164,100.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,372,317.90	22,751.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	170,801.00
OTHER IMAGING SERVICE	486,785.00	447.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	741,661.00	33,338.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	461,682.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,695,562.50	46,689.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	119,135.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	514,605.00	2,093.00			
			TOTAL ANCILLARY	55,780,884.99	1,457,079.80
			TOTAL ACCOMODATIONS	29,188,814.00	4,945,998.00
			TOTAL CHARGES	84,969,698.99	6,403,077.80

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015335006942	11/04/15 - 11/19/15	12/07/15	0.00	4,348.00	0.00	0.00	0.00
615	2015335007538	09/25/15 - 09/30/15	12/07/15	0.00	1,985.00	0.00	0.00	0.00
615	2015337008566	11/16/15 - 11/22/15	12/07/15	0.00	2,363.00	0.00	0.00	0.00
615	2015345004491	11/25/15 - 11/27/15	12/14/15	0.00	4,348.00	0.00	0.00	0.00
615	2315355000010	10/10/15 - 10/20/15	01/25/16	0.00	4,348.00	0.00	1,243.70	0.00
615	2015356008897	11/21/15 - 12/02/15	12/28/15	0.00	2,363.00	0.00	0.00	0.00
615	5215362006525	07/27/15 - 07/30/15	02/22/16	0.00	4,348.00	0.00	0.00	0.00
615	5215362006773	07/04/15 - 07/08/15	02/22/16	0.00	4,348.00	0.00	0.00	0.00
615	5215362007605	08/09/15 - 08/12/15	02/22/16	0.00	2,363.00	0.00	0.00	0.00
615	5215362017512	09/01/15 - 09/02/15	02/22/16	0.00	2,363.00	0.00	0.00	0.00
615	5215362018554	08/10/15 - 08/13/15	02/22/16	0.00	2,363.00	0.00	0.00	0.00
615	5215363001406	09/27/15 - 10/04/15	02/22/16	0.00	4,348.00	0.00	0.00	0.00
615	2316014000012	11/21/15 - 11/26/15	02/15/16	0.00	4,348.00	0.00	732.00	0.00
615	2316014000062	11/24/15 - 11/26/15	02/15/16	0.00	2,363.00	0.00	862.22	0.00
615	2016044003322	08/02/15 - 08/05/15	02/22/16	0.00	4,348.00	0.00	0.00	0.00
615	2316048000009	12/26/15 - 01/07/16	03/21/16	0.00	4,348.00	0.00	2,609.63	0.00
615	9816070001771	08/29/15 - 09/04/15	03/14/16	0.00	4,348.00	0.00	1,395.42	0.00
615	2016075005594	03/01/16 - 03/06/16	03/21/16	0.00	4,348.00	0.00	0.00	0.00
615	2016077002632	02/10/16 - 02/11/16	03/21/16	0.00	4,348.00	0.00	0.00	0.00
615	2316096000257	12/16/15 - 12/25/15	04/25/16	0.00	4,726.00	0.00	0.00	0.00
615	2316105000033	02/16/16 - 03/01/16	05/30/16	0.00	4,348.00	0.00	1,719.02	0.00
615	2316119000271	03/21/16 - 03/30/16	06/06/16	0.00	4,348.00	0.00	1,839.38	0.00
615	2016120010621	04/14/16 - 04/17/16	05/02/16	0.00	4,348.00	0.00	0.00	0.00
615	2016135006100	04/29/16 - 05/05/16	05/23/16	0.00	1,985.00	0.00	0.00	0.00
615	2316138000124	04/04/16 - 04/06/16	06/27/16	0.00	4,348.00	0.00	839.94	0.00
615	2316148000031	10/24/15 - 11/12/15	06/13/16	0.00	6,711.00	0.00	0.00	0.00
618	2316154000108	01/11/16 - 01/22/16	07/11/16	0.00	3,245.00	0.00	2,048.72	0.00
615	2316160000030	04/17/16 - 04/21/16	07/11/16	0.00	4,348.00	0.00	1,596.64	0.00
615	2316208000336	04/27/16 - 05/01/16	08/29/16	0.00	4,348.00	0.00	1,856.39	0.00
615	2216211006033	03/22/16 - 04/13/16	08/01/16	0.00	2,363.00	0.00	0.00	0.00
615	5916215000029	04/19/16 - 04/21/16	08/08/16	0.00	4,348.00	0.00	0.00	0.00
615	2016224096232	03/28/16 - 04/12/16	08/15/16	0.00	4,348.00	0.00	0.00	0.00
615	2016238005456	06/12/16 - 06/14/16	08/29/16	0.00	4,348.00	0.00	0.00	0.00
615	2316243000046	06/12/16 - 06/14/16	10/03/16	0.00	4,348.00	0.00	785.03	0.00
615	5216253000140	10/13/15 - 02/10/16	09/19/16	0.00	2,363.00	0.00	0.00	0.00
615	2216257000287	03/10/16 - 03/24/16	09/19/16	0.00	4,348.00	0.00	0.00	0.00
615	2016259006780	03/28/16 - 03/31/16	09/19/16	0.00	4,348.00	0.00	0.00	0.00
615	2316280000046	04/17/16 - 04/21/16	10/17/16	0.00	4,348.00	0.00	0.00	0.00
615	2316284000218	01/15/16 - 01/19/16	10/24/16	0.00	4,348.00	0.00	0.00	0.00
615	9816316000016	05/02/16 - 05/11/16	11/21/16	0.00	2,363.00	0.00	0.00	0.00
615	2016335086534	06/02/16 - 06/06/16	12/05/16	0.00	4,348.00	0.00	0.00	0.00
615	2016352005537	02/16/16 - 02/18/16	12/26/16	0.00	4,348.00	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

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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

615	2017129081008	02/14/16 - 02/16/16	05/15/17	0.00	4,348.00	0.00	0.00	0.00
615	2017166010505	10/25/15 - 10/27/15	06/19/17	0.00	4,790.00	0.00	0.00	0.00
TOTAL				0.00	170,801.00	0.00	17,528.09	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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	733,906.31	ADJUSTMENTS	0.00
COVERED CHARGES	705,700.31	CONTRACTUAL ALLOW	444,958.71
NON-COVERD CHARGES	28,206.00	TOTAL MEDICAID LIAB	260,741.60
		LESS: COB	260,741.60
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 33

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	90		0	129,150.00		28,206.00
ROUTINE NURSERY	10		0	20,012.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	100		0	149,162.00		28,206.00
SPECIAL CARE SERVICES						
CCU	1		0	3,998.00		0.00
ICU	24		0	66,196.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	25		0	70,194.00		0.00
TOTAL ACCOMODATIONS	125		0	219,356.00		28,206.00

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

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	54,365.00	0.00	OTHER LAB	10,627.00	0.00
MED/SURG SUPPLY	2,536.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	39,921.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,760.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,326.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,547.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	7,562.00	0.00	MRI SERVICES	2,950.00	0.00
IV THERAPY	4,054.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	62,719.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	10,922.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,981.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	33,137.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,725.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	38,798.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,214.00	0.00	INJECTABLE DRUGS	39,163.31	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	382.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	9,114.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	20,158.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,501.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	735.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,639.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	73,301.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	756.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,451.00	0.00			
			TOTAL ANCILLARY	486,344.31	0.00
			TOTAL ACCOMODATIONS	219,356.00	28,206.00
			TOTAL CHARGES	705,700.31	28,206.00

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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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	30,923,955.54	ADJUSTMENTS	871,038.29
COVERED CHARGES	27,490,821.17	CONTRACTUAL ALLOW	22,298,146.07
NON-COVERD CHARGES	3,433,134.37	TOTAL MEDICAID LIAB	5,192,675.10
		LESS: COB	13,844.47
		LESS: COPAYMENT	12,368.07
		REIMBURSEMENT	5,166,462.56
		ALL OTHER	3,595,420.00
		FEE SCHEDULE-LAB	241,132.01
		INJECTABLE DRUGS	1,329,910.55

TOTAL NUMBER OF CLAIMS 9,772

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	472,421.20	4.00	OTHER LAB	305,828.00	0.00
MED/SURG SUPPLY	74,772.00	1,228.00	RECREATIONAL THERAPY	139.00	0.00
LABORATORY-GENERAL	0.00	7,880.00	EDUCATION & TRAINING	40.00	565.00
RADIOLOGY-DIAGNOSTIC	1,394,347.00	10,318.00	OTHER THERAPEUTIC SVC	0.00	81,732.00
CT SCAN	3,016,818.00	627,386.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	77,618.00	11,791.06	FEE SCHEDULE LAB	2,468,609.00	149,746.00
EKG/ECG	501,666.00	5,970.00	MRI SERVICES	304,184.00	100,810.00
IV THERAPY	1,775,241.00	53,675.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,846,190.07	249,027.93	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,210.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	122,552.00	49,296.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	522,701.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	147,992.00	31,851.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,841,444.00	24,145.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	474,817.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,472,182.37	436,649.28
RADIOLOGY THERAPEUTIC	0.00	3,960.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,073.00	2,128.03	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	342.00	4,182.07	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	138,229.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	153,018.53	5,581.00	TRAUMA RESPONSE	0.00	71,100.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	24,925.00	537,987.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	26,520.00
OTHER IMAGING SERVICE	966,627.00	167,332.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	41,940.00	1,101.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	703,183.00	226,947.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,277,790.00	403,846.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,537.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	491,614.00	2,147.00			
			TOTAL ANCILLARY	27,490,821.17	3,433,134.37
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	27,490,821.17	3,433,134.37

SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER
 000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5915231000077	07/25/15 - 07/25/15	08/24/15	0.00	2,363.00	0.00	0.00	0.00
615	5915231000077	07/25/15 - 07/25/15	08/24/15	0.00	1,985.00	0.00	0.00	0.00
615	5915309000219	09/30/15 - 09/30/15	11/09/15	0.00	2,363.00	0.00	0.00	0.00
615	2015310073097	10/12/15 - 10/12/15	11/09/15	0.00	2,363.00	0.00	0.00	0.00
615	2216013010352	11/25/15 - 11/25/15	01/18/16	0.00	2,363.00	0.00	0.00	0.00
615	2216013010352	11/25/15 - 11/25/15	01/18/16	0.00	1,985.00	0.00	0.00	0.00
615	5916055000211	01/09/16 - 01/09/16	02/29/16	0.00	1,985.00	0.00	0.00	0.00
615	2016140004584	04/18/16 - 04/18/16	05/23/16	0.00	2,363.00	0.00	0.00	0.00
615	2016140004584	04/18/16 - 04/18/16	05/23/16	0.00	1,985.00	0.00	0.00	0.00
615	2016229011175	02/26/16 - 02/26/16	08/22/16	0.00	2,363.00	0.00	0.00	0.00
615	2016229011175	02/26/16 - 02/26/16	08/22/16	0.00	1,985.00	0.00	0.00	0.00
8446	2216267014221	04/28/16 - 04/28/16	09/26/16	0.00	54.00	0.00	0.00	0.00
615	5917018000881	06/09/16 - 06/09/16	01/23/17	0.00	2,363.00	0.00	0.00	0.00
TOTAL				0.00	26,520.00	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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	406,440.00	ADJUSTMENTS	0.00
COVERED CHARGES	299,222.50	CONTRACTUAL ALLOW	155,414.45
NON-COVERD CHARGES	107,217.50	TOTAL MEDICAID LIAB	143,808.05
		LESS: COB	143,720.19
		LESS: COPAYMENT	87.86
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 101

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,718.00	0.00	OTHER LAB	1,650.00	0.00
MED/SURG SUPPLY	1,609.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,720.00	0.00	OTHER THERAPEUTIC SVC	0.00	1,112.00
CT SCAN	6,862.00	50,680.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,193.00	819.00	FEE SCHEDULE LAB	28,943.00	1,739.00
EKG/ECG	5,970.00	0.00	MRI SERVICES	0.00	6,651.00
IV THERAPY	17,606.00	612.00	PROFESSIONAL FEES	0.00	43.00
OPERATING ROOM	49,399.50	2,584.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	322.00	483.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,228.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,937.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	51,868.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,816.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	42,837.00	2,399.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	4,176.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,681.00	68.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,880.00	19,535.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,004.00	5,048.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	6,031.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	18,922.00	2,300.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,994.00	0.00			
			TOTAL ANCILLARY	299,222.50	107,217.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	299,222.50	107,217.50

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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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,361,951.40	ADJUSTMENTS	913.50
COVERED CHARGES	1,292,331.40	CONTRACTUAL ALLOW	1,246,460.60
NON-COVERD CHARGES	69,620.00	TOTAL MEDICAID LIAB	45,870.80
		LESS: COB	0.00
		LESS: COPAYMENT	1,032.81
		REIMBURSEMENT	44,837.99
		TOTAL NUMBER OF CLAIMS	820

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,289.00	0.00	OTHER LAB	14,835.00	0.00
MED/SURG SUPPLY	595.00	89.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	794.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	81,299.00	0.00	OTHER THERAPEUTIC SVC	0.00	12,093.00
CT SCAN	128,800.00	25,400.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	182,403.00	12,852.00
EKG/ECG	18,706.00	0.00	MRI SERVICES	0.00	2,713.00
IV THERAPY	66,335.00	526.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,619.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,691.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,073.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	675,708.00	729.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,568.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	30,270.40	2,445.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	48,551.00	11,979.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,589.00	0.00			
			TOTAL ANCILLARY	1,292,331.40	69,620.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,292,331.40	69,620.00

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	38,106.00	ADJUSTMENTS	0.00
COVERED CHARGES	30,623.00	CONTRACTUAL ALLOW	21,149.47
NON-COVERD CHARGES	7,483.00	TOTAL MEDICAID LIAB	9,473.53
		LESS: COB	9,461.53
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	697.00	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	1,179.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,256.00	5,440.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,722.00	0.00
EKG/ECG	796.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,190.00	137.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	276.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,411.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,096.00	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	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,906.00			
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	30,623.00	7,483.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	30,623.00	7,483.00

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,005,416.00	ADJUSTMENTS	234,628.96
COVERED CHARGES	2,903,147.00	CONTRACTUAL ALLOW	2,241,850.92
NON-COVERD CHARGES	102,269.00	TOTAL MEDICAID LIAB	661,296.08
		LESS: COB	0.00
		LESS: COPAYMENT	396.00
		REIMBURSEMENT	660,900.08
		TOTAL NUMBER OF CLAIMS	118

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,871.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,128.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,789.00	748.00	OTHER THERAPEUTIC SVC	0.00	139.00
CT SCAN	43,638.00	7,348.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	344.00	688.00	FEE SCHEDULE LAB	40,918.00	2,391.00
EKG/ECG	7,562.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	164,283.00	3,155.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	261,785.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,622.00	805.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	58,706.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,475.00	729.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	25,182.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,826,623.00	9,124.00
RADIOLOGY THERAPEUTIC	0.00	720.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	242.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	669.00	0.00	TRAUMA RESPONSE	0.00	10,200.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	29,014.00	60,981.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,222.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	356,156.00	4,999.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	26,160.00	0.00			
			TOTAL ANCILLARY	2,903,147.00	102,269.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,903,147.00	102,269.00

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

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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,694,165.72	ADJUSTMENTS	0.00
COVERED CHARGES	1,675,229.72	CONTRACTUAL ALLOW	1,189,778.68
NON-COVERD CHARGES	18,936.00	TOTAL MEDICAID LIAB	485,451.04
		LESS: COB	20,020.71
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	465,430.33

TOTAL NUMBER OF ADMISSIONS 53

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	134		0	132,792.00		7,454.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	134		0	132,792.00		7,454.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	122		0	243,331.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	243,331.00		0.00
TOTAL ACCOMODATIONS	256		0	376,123.00		7,454.00

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	129,578.72	0.00	OTHER LAB	1,989.00	0.00
MED/SURG SUPPLY	144,364.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	286,067.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	30,678.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	108,152.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,815.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	23,490.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	48,610.00	6,658.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	114,626.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	112,728.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,867.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	15,456.00	0.00	INJECTABLE DRUGS	211,548.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	233.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,010.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,648.00	4,824.00			
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	20,883.00	0.00			
			TOTAL ANCILLARY	1,299,106.72	11,482.00
			TOTAL ACCOMODATIONS	376,123.00	7,454.00
			TOTAL CHARGES	1,675,229.72	18,936.00

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	01/01/16	THROUGH	12/31/16
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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CANDLER COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,655,686.63	ADJUSTMENTS	75,718.52
COVERED CHARGES	2,461,834.04	CONTRACTUAL ALLOW	1,952,951.08
NON-COVERD CHARGES	193,852.59	TOTAL MEDICAID LIAB	508,882.96
		LESS: COB	96.21
		LESS: COPAYMENT	1,044.00
		REIMBURSEMENT	507,742.75
		ALL OTHER	474,990.66
		FEE SCHEDULE-LAB	30,815.20
		INJECTABLE DRUGS	1,936.89
		TOTAL NUMBER OF CLAIMS	1,021

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

PROVIDER NUMBER
 000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,406.54	7,501.52	OTHER LAB	8,604.00	0.00
MED/SURG SUPPLY	236,722.00	56.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	269.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	133,388.00	256.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	306,248.00	34,525.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,646.00	5,660.00	FEE SCHEDULE LAB	511,573.80	20,175.40
EKG/ECG	74,218.00	1,052.00	MRI SERVICES	59,581.00	3,687.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	363,725.00	58,794.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	25,231.00	7,861.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	425,771.00	5,428.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	123,082.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	41,726.70	16,066.67
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	612.00	69.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	146.00	146.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	14,748.00
OTHER IMAGING SERVICE	30,704.00	5,214.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	14,304.00	5,364.00			
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	64,145.00	6,980.00			
			TOTAL ANCILLARY	2,461,834.04	193,852.59
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,461,834.04	193,852.59

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

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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016128013836	03/15/16 - 03/15/16	05/16/16	0.00	3,687.00	0.00	0.00	0.00
615	5916168001702	05/31/16 - 05/31/16	06/20/16	0.00	3,687.00	0.00	0.00	0.00
615	5916168001702	05/31/16 - 05/31/16	06/20/16	0.00	3,687.00	0.00	0.00	0.00
615	5917023000530	11/07/16 - 11/07/16	01/30/17	0.00	3,687.00	0.00	0.00	0.00
TOTAL				0.00	14,748.00	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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,115.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,087.00	CONTRACTUAL ALLOW	728.82
NON-COVERD CHARGES	28.00	TOTAL MEDICAID LIAB	1,358.18
		LESS: COB	1,355.18
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 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	643.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,444.00	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	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	2,087.00	28.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,087.00	28.00

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

PROVIDER NUMBER
000000316A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	357,421.94	ADJUSTMENTS	472.83
COVERED CHARGES	338,820.70	CONTRACTUAL ALLOW	329,520.70
NON-COVERD CHARGES	18,601.24	TOTAL MEDICAID LIAB	9,300.00
		LESS: COB	0.00
		LESS: COPAYMENT	391.00
		REIMBURSEMENT	8,909.00
		TOTAL NUMBER OF CLAIMS	186

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,404.90	37.00	OTHER LAB	514.00	0.00
MED/SURG SUPPLY	18,053.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,936.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	81,671.00	11,105.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	57,619.00	2,687.00
EKG/ECG	5,946.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,328.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,746.00	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	143,199.00	873.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	999.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,404.80	3,116.24
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	76.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	707.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	338,820.70	18,601.24
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	338,820.70	18,601.24

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 COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,529.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,501.00	CONTRACTUAL ALLOW	1,006.00
NON-COVERD CHARGES	28.00	TOTAL MEDICAID LIAB	495.00
		LESS: COB	495.00
		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

Run Date: 08/24/2017
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
 000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	56.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	930.00	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	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	500.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,501.00	28.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,501.00	28.00

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

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

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	66,559.44	ADJUSTMENTS	4,862.89
COVERED CHARGES	62,403.40	CONTRACTUAL ALLOW	52,677.62
NON-COVERD CHARGES	4,156.04	TOTAL MEDICAID LIAB	9,725.78
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	9,722.78

TOTAL NUMBER OF CLAIMS 2

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,887.90	56.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,443.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,107.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,035.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,521.00	112.00
EKG/ECG	1,248.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	27,314.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	977.00	1,680.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,250.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	999.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	122.50	520.04
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,788.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,499.00	0.00			
			TOTAL ANCILLARY	62,403.40	4,156.04
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	62,403.40	4,156.04

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: 08/24/2017
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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	01/01/16	THROUGH	12/31/16
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

CANDLER HOSPITAL
 5353 REYNOLDS ST
 SAVANNAH,GA 31405-6005

PROVIDER NUMBER 000000327A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,348,336.04	ADJUSTMENTS	1,489,788.27
COVERED CHARGES	26,777,196.70	CONTRACTUAL ALLOW	20,223,908.48
NON-COVERD CHARGES	571,139.34	TOTAL MEDICAID LIAB	6,553,288.22
		LESS: COB	107,643.90
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,445,644.32

TOTAL NUMBER OF ADMISSIONS 634

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,733		0	2,380,263.00		75,847.00
ROUTINE NURSERY	324		0	243,706.00		106,565.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,057		0	2,623,969.00		182,412.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,907		0	3,415,588.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,907		0	3,415,588.00		0.00
TOTAL ACCOMODATIONS	4,964		0	6,039,557.00		182,412.00

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

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

Run Date: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,840,380.28	73,127.00	OTHER LAB	88,885.00	598.00
MED/SURG SUPPLY	707,135.21	2,886.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,824,375.00	26,172.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	944,355.00	2,479.00	OTHER THERAPEUTIC SVC	0.00	43,845.00
CT SCAN	1,164,923.00	38,175.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	223,584.24	2,833.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	82,541.00	0.00	MRI SERVICES	268,272.00	0.00
IV THERAPY	539,136.00	1,925.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,163,657.58	44,356.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	273,573.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,845,604.00	4.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	494,641.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	116,906.00	5,144.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	490,450.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	284,484.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	97,736.00	0.00	INJECTABLE DRUGS	3,388,429.25	23,249.00
RADIOLOGY THERAPEUTIC	98,161.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	98,520.09	2,781.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	74,560.05	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	303,229.00	35,650.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	200.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	245,145.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	111,603.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	533,839.00	22,326.34			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	86,754.00	63,177.00			
AUDIOLOGY	476.00	0.00			
CARDIOLOGY	125,273.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	71,334.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	149,478.00	0.00			
			TOTAL ANCILLARY	20,737,639.70	388,727.34
			TOTAL ACCOMODATIONS	6,039,557.00	182,412.00
			TOTAL CHARGES	26,777,196.70	571,139.34

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	211,938.00	ADJUSTMENTS	0.00
COVERED CHARGES	211,938.00	CONTRACTUAL ALLOW	137,916.47
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	74,021.53
		LESS: COB	74,021.53
		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	33		0	28,875.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	33		0	28,875.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	9		0	22,836.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	22,836.00		0.00
TOTAL ACCOMODATIONS	42		0	51,711.00		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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,811.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,647.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	21,203.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,533.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	149.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,548.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,102.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	49,720.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	26,426.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,656.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,038.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,982.00	0.00	INJECTABLE DRUGS	13,059.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	353.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	160,227.00	0.00
			TOTAL ACCOMODATIONS	51,711.00	0.00
			TOTAL CHARGES	211,938.00	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: 08/24/2017
Run Time: 02:12:17
Page: 5

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,578,361.12	ADJUSTMENTS	195,411.83
COVERED CHARGES	17,982,807.18	CONTRACTUAL ALLOW	14,755,869.45
NON-COVERD CHARGES	1,595,553.94	TOTAL MEDICAID LIAB	3,226,937.73
		LESS: COB	21,302.87
		LESS: COPAYMENT	10,306.11
		REIMBURSEMENT	3,195,328.75
		ALL OTHER	2,935,820.31
		FEE SCHEDULE-LAB	252,728.80
		INJECTABLE DRUGS	6,779.64
		TOTAL NUMBER OF CLAIMS	8,186

CANDLER HOSPITAL
 5353 REYNOLDS ST
 SAVANNAH,GA 31405-6005

PROVIDER NUMBER
 000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,366,861.15	4,965.72	OTHER LAB	157,026.00	0.00
MED/SURG SUPPLY	321,692.63	31,629.39	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	827,900.00	17,596.00	OTHER THERAPEUTIC SVC	37,449.00	13,466.00
CT SCAN	1,425,209.00	237,715.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,379.00	4,565.19	FEE SCHEDULE LAB	2,081,575.00	138,318.00
EKG/ECG	79,553.00	2,533.00	MRI SERVICES	212,566.00	23,846.00
IV THERAPY	1,382,880.00	57,840.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,475,437.16	315,456.59	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	69,719.00	31,221.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	557,142.00	3,912.00	AMBULANCE	0.00	0.00
GI SERVICES	75,520.00	9,264.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,041,923.50	13,542.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	471,903.00	1,733.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	93,570.24	51,153.44
RADIOLOGY THERAPEUTIC	1,622,223.00	82,945.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,919.00	1,086.08	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	457.00	2,181.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	6,676.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	11,826.00	27.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	113,986.00	202,429.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	817,778.00	146,731.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	230,915.00	40,640.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	74,287.00	129,788.00			
AUDIOLOGY	0.00	3,622.00			
CARDIOLOGY	17,603.00	5,310.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	79,767.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	318,740.50	15,362.00			
			TOTAL ANCILLARY	17,982,807.18	1,595,553.94
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,982,807.18	1,595,553.94

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

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	388,182.92	ADJUSTMENTS	0.00
COVERED CHARGES	230,733.92	CONTRACTUAL ALLOW	122,872.99
NON-COVERD CHARGES	157,449.00	TOTAL MEDICAID LIAB	107,860.93
		LESS: COB	107,751.15
		LESS: COPAYMENT	109.78
		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

CANDLER HOSPITAL
 5353 REYNOLDS ST
 SAVANNAH,GA 31405-6005

PROVIDER NUMBER
 000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,064.38	53.00	OTHER LAB	8,967.00	0.00
MED/SURG SUPPLY	11,864.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,667.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,507.00	26,572.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	394.00	FEE SCHEDULE LAB	19,247.00	2,231.00
EKG/ECG	1,043.00	0.00	MRI SERVICES	0.00	15,581.00
IV THERAPY	19,136.00	363.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	45,239.00	16,763.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	543.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,453.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,544.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	36,705.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,328.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,771.54	2,930.00
RADIOLOGY THERAPEUTIC	5,236.00	1,368.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	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	0.00	83,061.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,204.00	4,940.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,861.00	368.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,155.00	780.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,743.00	301.00			
			TOTAL ANCILLARY	230,733.92	157,449.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	230,733.92	157,449.00

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	636,980.68	ADJUSTMENTS	329.64
COVERED CHARGES	603,181.68	CONTRACTUAL ALLOW	576,666.12
NON-COVERD CHARGES	33,799.00	TOTAL MEDICAID LIAB	26,515.56
		LESS: COB	71.34
		LESS: COPAYMENT	963.85
		REIMBURSEMENT	25,480.37
		TOTAL NUMBER OF CLAIMS	474

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,343.68	0.00	OTHER LAB	7,772.00	0.00
MED/SURG SUPPLY	135.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	44,318.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	42,419.00	10,739.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	82,040.00	4,323.00
EKG/ECG	4,917.00	149.00	MRI SERVICES	4,633.00	5,480.00
IV THERAPY	82,293.00	1,699.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	834.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,596.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	269,420.00	1,969.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,890.00	106.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,068.00	9,334.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,642.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	664.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,197.00	0.00			
			TOTAL ANCILLARY	603,181.68	33,799.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	603,181.68	33,799.00

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,956.86	ADJUSTMENTS	0.00
COVERED CHARGES	14,340.86	CONTRACTUAL ALLOW	11,420.49
NON-COVERD CHARGES	1,616.00	TOTAL MEDICAID LIAB	2,920.37
		LESS: COB	2,895.94
		LESS: COPAYMENT	24.43
		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

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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 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	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	427.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,364.00	803.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,216.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,602.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,979.86	413.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	400.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	14,340.86	1,616.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,340.86	1,616.00

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,360,152.71	ADJUSTMENTS	27,681.01
COVERED CHARGES	1,258,638.74	CONTRACTUAL ALLOW	1,086,812.69
NON-COVERD CHARGES	101,513.97	TOTAL MEDICAID LIAB	171,826.05
		LESS: COB	3,876.65
		LESS: COPAYMENT	94.54
		REIMBURSEMENT	167,854.86
		TOTAL NUMBER OF CLAIMS	31

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	556,946.24	4.94	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	50,786.00	448.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	46,170.00	10,007.00	OTHER THERAPEUTIC SVC	0.00	26,142.00
CT SCAN	4,419.00	4,419.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	394.00	485.03	FEE SCHEDULE LAB	8,430.00	16.00
EKG/ECG	447.00	149.00	MRI SERVICES	4,721.00	0.00
IV THERAPY	28,261.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	159,244.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	724.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	39,141.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	769.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	23,508.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	30,349.00	406.00
RADIOLOGY THERAPEUTIC	38,222.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	158,269.00	56,385.00
LITHOTRIPSY	94,008.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,008.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,554.00	3,052.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	268.00	0.00			
			TOTAL ANCILLARY	1,258,638.74	101,513.97
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,258,638.74	101,513.97

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: 08/24/2017
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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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 02/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,818,329.98	ADJUSTMENTS	1,069,055.79
COVERED CHARGES	26,894,476.39	CONTRACTUAL ALLOW	17,640,837.43
NON-COVERD CHARGES	923,853.59	TOTAL MEDICAID LIAB	9,253,638.96
		LESS: COB	3,217.45
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,250,421.51

TOTAL NUMBER OF ADMISSIONS 1,295

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,356		0	3,400,974.00		152,495.00
ROUTINE NURSERY	1,095		0	1,956,420.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	4,451		0	5,357,394.00		152,495.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	463		0	1,260,286.00		0.00
NICU	117		0	390,387.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	580		0	1,650,673.00		0.00
TOTAL ACCOMODATIONS	5,031		0	7,008,067.00		152,495.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 02/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,808,717.74	0.00	OTHER LAB	117,466.24	0.00
MED/SURG SUPPLY	954,515.59	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,913,235.96	0.00	EDUCATION & TRAINING	47,097.79	0.00
RADIOLOGY-DIAGNOSTIC	430,617.06	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	843,760.92	368,868.55	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	95,589.92	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	225,593.95	0.00	MRI SERVICES	348,993.87	0.00
IV THERAPY	150,272.39	0.00	PROFESSIONAL FEES	0.00	22.05
OPERATING ROOM	846,406.02	5,027.40	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	568,882.09	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,937,126.62	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	263,779.20	0.00	AMBULANCE	0.00	0.00
GI SERVICES	170,589.30	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,968,911.47	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	221,537.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	134,874.26	0.00	INJECTABLE DRUGS	88.35	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	24,291.80	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	26,525.66	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	160,263.60	6,577.52	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	58,932.88	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	349,380.95	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	202,534.84	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	302,538.49	10,010.82			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	330,749.43	68,890.95			
AUDIOLOGY	49,201.95	311,961.30			
CARDIOLOGY	1,195,663.95	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	19,593.90	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	118,675.80	0.00			
			TOTAL ANCILLARY	19,886,409.39	771,358.59
			TOTAL ACCOMODATIONS	7,008,067.00	152,495.00
			TOTAL CHARGES	26,894,476.39	923,853.59

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

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

Run Date: 08/24/2017
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 Page: 3

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 02/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,929.34	ADJUSTMENTS	0.00
COVERED CHARGES	24,593.34	CONTRACTUAL ALLOW	7,284.76
NON-COVERD CHARGES	336.00	TOTAL MEDICAID LIAB	17,308.58
		LESS: COB	17,308.58
		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	6		0	6,120.00		336.00
ROUTINE NURSERY	0		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	6,120.00		336.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	6,120.00		336.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 02/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,875.28	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,345.84	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,312.66	0.00	EDUCATION & TRAINING	371.70	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	2,238.60	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,771.45	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,072.05	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,485.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	627.90	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	372.11	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	18,473.34	0.00
			TOTAL ACCOMODATIONS	6,120.00	336.00
			TOTAL CHARGES	24,593.34	336.00

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

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 02/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,006,866.72	ADJUSTMENTS	493,823.89
COVERED CHARGES	16,092,771.25	CONTRACTUAL ALLOW	13,686,122.57
NON-COVERD CHARGES	1,914,095.47	TOTAL MEDICAID LIAB	2,406,648.68
		LESS: COB	6,550.18
		LESS: COPAYMENT	3,572.96
		REIMBURSEMENT	2,396,525.54
		ALL OTHER	2,205,884.81
		FEE SCHEDULE-LAB	170,452.14
		INJECTABLE DRUGS	20,188.59

TOTAL NUMBER OF CLAIMS 4,974

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

PROVIDER NUMBER
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 02/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	176,703.41	21,724.13	OTHER LAB	137,387.17	6,767.13
MED/SURG SUPPLY	170,900.30	24,488.22	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	129.15	EDUCATION & TRAINING	0.00	71.40
RADIOLOGY-DIAGNOSTIC	617,562.99	31,857.42	OTHER THERAPEUTIC SVC	0.00	6,655.04
CT SCAN	1,362,338.61	281,731.17	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	65,056.54	18,849.81	FEE SCHEDULE LAB	4,518,473.10	256,070.48
EKG/ECG	197,086.55	17,722.45	MRI SERVICES	416,993.39	50,556.02
IV THERAPY	238,626.14	30,932.85	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	909,965.70	102,385.79	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	79,577.50	5,811.14	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	180,340.98	356,369.84	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	293,035.05	0.00	AMBULANCE	0.00	0.00
GI SERVICES	317,032.27	42,287.18	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,674,606.25	109,775.88	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	215,191.20	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	186,760.16	50,879.98
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	12,535.70	7,235.60	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	14,006.83	5,752.80	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	46,675.79	6,431.12	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	17,467.31	31,104.30
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	6,659.10
OTHER IMAGING SERVICE	828,175.21	244,277.33			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	35,871.66	6,034.18			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	86,661.02	113,626.21			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	210,267.44	77,628.35			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	238.35	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	83,234.63	281.40			
			TOTAL ANCILLARY	16,092,771.25	1,914,095.47
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,092,771.25	1,914,095.47

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

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 02/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016341000689	11/29/16 - 11/29/16	12/12/16	0.00	5,980.80	0.00	0.00	0.00
614	5916343000357	09/02/16 - 09/02/16	12/12/16	0.00	678.30	0.00	0.00	0.00
TOTAL				0.00	6,659.10	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

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

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 02/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,688.66	ADJUSTMENTS	0.00
COVERED CHARGES	18,694.50	CONTRACTUAL ALLOW	9,751.35
NON-COVERD CHARGES	3,994.16	TOTAL MEDICAID LIAB	8,943.15
		LESS: COB	8,940.15
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 8

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

PRIME HEALTHCARE FOUNDATION-SOUTHERN REGIONAL LLC PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
 11 UPPER RIVERDALE RD SW 000000404A SERVICE DATES 02/01/16 THROUGH 12/31/16
 RIVERDALE,GA 30274-2615 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	89.08	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	49.91	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,602.30	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,205.40	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,292.81	310.74
EKG/ECG	335.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	632.60	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	6,288.80	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,290.10	77.54
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	2,383.50	2,326.98			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,638.00	73.50			
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	92.40	0.00			
			TOTAL ANCILLARY	18,694.50	3,994.16
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,694.50	3,994.16

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

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 02/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	478,519.51	ADJUSTMENTS	694.96
COVERED CHARGES	463,301.11	CONTRACTUAL ALLOW	444,673.09
NON-COVERD CHARGES	15,218.40	TOTAL MEDICAID LIAB	18,628.02
		LESS: COB	3.99
		LESS: COPAYMENT	578.47
		REIMBURSEMENT	18,045.56
		TOTAL NUMBER OF CLAIMS	333

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 02/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,325.54	126.12	OTHER LAB	1,672.65	0.00
MED/SURG SUPPLY	469.65	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,501.81	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,179.08	2,425.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	133,539.59	8,417.51
EKG/ECG	5,684.15	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	224.54	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	594.30	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	484.09	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	268,995.15	796.14	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,263.48	69.67
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	129.15	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,237.93	3,383.46			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	463,301.11	15,218.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	463,301.11	15,218.40

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

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

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 02/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,002.55	ADJUSTMENTS	0.00
COVERED CHARGES	5,971.05	CONTRACTUAL ALLOW	2,656.01
NON-COVERD CHARGES	31.50	TOTAL MEDICAID LIAB	3,315.04
		LESS: COB	3,312.04
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 02/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,261.65	31.50
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	1,709.40	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	5,971.05	31.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,971.05	31.50

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

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

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 02/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	385,369.51	ADJUSTMENTS	16,623.69
COVERED CHARGES	357,382.27	CONTRACTUAL ALLOW	313,020.43
NON-COVERD CHARGES	27,987.24	TOTAL MEDICAID LIAB	44,361.84
		LESS: COB	0.00
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	44,343.84

TOTAL NUMBER OF CLAIMS 8

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

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

PROVIDER NUMBER
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 02/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,043.26	57.60	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	15,004.56	2,545.57	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,874.97	655.20	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,733.99	2,425.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	802.23	FEE SCHEDULE LAB	15,715.03	496.50
EKG/ECG	929.35	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,244.93	4,554.39	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	111,682.65	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	21,677.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,916.49	1,954.14	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,165.05	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	77,750.37	4,844.96
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	64,857.02	3,080.25
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	784.35	1,810.20			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	4,760.70			
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	3,003.00	0.00			
			TOTAL ANCILLARY	357,382.27	27,987.24
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	357,382.27	27,987.24

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

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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PRIME HEALTHCARE FOUNDATION-SOUTHERN REGIONAL LLC	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
11 UPPER RIVERDALE RD SW	000000404A	SERVICE DATES	02/01/16	THROUGH	12/31/16
RIVERDALE,GA 30274-2615		ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 01/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,876,391.55	ADJUSTMENTS	2,274,340.93
COVERED CHARGES	19,240,588.08	CONTRACTUAL ALLOW	13,362,678.38
NON-COVERD CHARGES	635,803.47	TOTAL MEDICAID LIAB	5,877,909.70
		LESS: COB	37,010.15
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,840,899.55

TOTAL NUMBER OF ADMISSIONS 882

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,663		0	2,697,417.00		105,528.00
ROUTINE NURSERY	862		2	1,603,105.00		1,910.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,525		2	4,300,522.00		107,438.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	423		0	1,151,406.00		0.00
NICU	11		0	42,313.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	434		0	1,193,719.00		0.00
TOTAL ACCOMODATIONS	3,959		2	5,494,241.00		107,438.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 01/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,101,827.62	0.00	OTHER LAB	109,591.65	0.00
MED/SURG SUPPLY	854,191.53	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,332,617.61	0.00	EDUCATION & TRAINING	30,716.70	0.00
RADIOLOGY-DIAGNOSTIC	276,368.89	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	536,831.40	207,671.10	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	77,426.22	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	118,522.95	0.00	MRI SERVICES	243,381.60	0.00
IV THERAPY	61,556.80	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	661,280.09	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	366,445.80	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,308,173.22	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	242,833.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	169,627.50	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,138,268.36	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	197,056.65	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	128,649.15	0.00	INJECTABLE DRUGS	807.92	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	28,510.69	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	46,774.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	141,189.30	21,117.60	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	45,734.85	223.87	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	131,654.88	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	132,726.91	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	264,709.20	7,123.20			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	169,079.40	43,079.40			
AUDIOLOGY	31,405.50	249,150.30			
CARDIOLOGY	625,087.34	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	10,760.40	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	162,538.95	0.00			
			TOTAL ANCILLARY	13,746,347.08	528,365.47
			TOTAL ACCOMODATIONS	5,494,241.00	107,438.00
			TOTAL CHARGES	19,240,588.08	635,803.47

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 01/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	155,173.98	ADJUSTMENTS	0.00
COVERED CHARGES	152,979.93	CONTRACTUAL ALLOW	110,125.65
NON-COVERD CHARGES	2,194.05	TOTAL MEDICAID LIAB	42,854.28
		LESS: COB	42,854.28
		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	15		0	15,300.00		1,248.00
ROUTINE NURSERY	0		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	15,300.00		1,248.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	15,300.00		1,248.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 01/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,223.75	0.00	OTHER LAB	970.20	0.00
MED/SURG SUPPLY	14,954.91	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,602.50	0.00	EDUCATION & TRAINING	185.85	0.00
RADIOLOGY-DIAGNOSTIC	12,890.85	0.00	OTHER THERAPEUTIC SVC	0.00	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	778.05	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	4,004.70	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,551.97	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	3,813.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,158.80	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,528.00	946.05			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	70,690.20	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	3,326.40	0.00			
			TOTAL ANCILLARY	137,679.93	946.05
			TOTAL ACCOMODATIONS	15,300.00	1,248.00
			TOTAL CHARGES	152,979.93	2,194.05

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: 08/24/2017
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PRIME HEALTHCARE FOUNDATION-SOUTHERN REGIONAL LLC
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 01/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,815,092.41	ADJUSTMENTS	196,842.60
COVERED CHARGES	11,050,967.37	CONTRACTUAL ALLOW	9,226,639.68
NON-COVERD CHARGES	1,764,125.04	TOTAL MEDICAID LIAB	1,824,327.69
		LESS: COB	2,007.67
		LESS: COPAYMENT	3,049.04
		REIMBURSEMENT	1,819,270.98
		ALL OTHER	1,644,796.27
		FEE SCHEDULE-LAB	151,302.96
		INJECTABLE DRUGS	23,171.75

TOTAL NUMBER OF CLAIMS 3,876

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

PROVIDER NUMBER
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 01/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	181,850.53	33,769.58	OTHER LAB	191,152.50	238.35
MED/SURG SUPPLY	153,504.79	18,106.48	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	185.85	1,927.80
RADIOLOGY-DIAGNOSTIC	456,347.46	4,922.40	OTHER THERAPEUTIC SVC	0.00	4,703.50
CT SCAN	792,108.45	308,546.70	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	36,488.55	11,406.15	FEE SCHEDULE LAB	2,612,107.96	241,089.90
EKG/ECG	136,418.10	17,635.80	MRI SERVICES	126,235.20	50,393.70
IV THERAPY	184,627.52	9,051.58	PROFESSIONAL FEES	0.00	44.10
OPERATING ROOM	521,732.23	112,111.82	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	52,670.10	953.40	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	46,100.25	6,934.20	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	280,185.15	0.00	AMBULANCE	0.00	0.00
GI SERVICES	295,287.30	61,469.10	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,561,017.69	77,835.65	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	189,023.10	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	148,145.27	141,342.05
RADIOLOGY THERAPEUTIC	13,407.29	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,128.20	4,201.05	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,486.80	1,982.43	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	11,111.10	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	90,831.17	11,674.72	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,700.99	99,122.28
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	496,994.92	216,848.10			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	37,529.10	12,475.05			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	84,175.35	148,623.30			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	142,021.95	143,711.40			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,345.05	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	210,158.55	11,893.35			
			TOTAL ANCILLARY	11,050,967.37	1,764,125.04
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,050,967.37	1,764,125.04

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

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

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 01/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	85,568.88	ADJUSTMENTS	0.00
COVERED CHARGES	53,267.90	CONTRACTUAL ALLOW	30,736.68
NON-COVERD CHARGES	32,300.98	TOTAL MEDICAID LIAB	22,531.22
		LESS: COB	22,516.41
		LESS: COPAYMENT	14.81
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 31

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

PRIME HEALTHCARE FOUNDATION-SOUTHERN REGIONAL LLC PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
 11 UPPER RIVERDALE RD SW 000000404A SERVICE DATES 07/01/15 THROUGH 01/31/16
 RIVERDALE,GA 30274-2615 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,482.92	124.32	OTHER LAB	0.00	1,873.20
MED/SURG SUPPLY	1,394.27	296.10	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,278.90	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	14,675.85	838.95
EKG/ECG	518.70	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,883.30	424.65	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,066.90	238.35	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,639.30	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	6,772.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,135.60	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	787.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	489.61	331.81
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	129.15	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,420.50	5,647.95			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	15,624.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	448.35	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	46.20	0.00			
			TOTAL ANCILLARY	53,267.90	32,300.98
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	53,267.90	32,300.98

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

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 01/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	318,091.66	ADJUSTMENTS	329.64
COVERED CHARGES	300,512.52	CONTRACTUAL ALLOW	287,086.92
NON-COVERD CHARGES	17,579.14	TOTAL MEDICAID LIAB	13,425.60
		LESS: COB	0.00
		LESS: COPAYMENT	449.10
		REIMBURSEMENT	12,976.50
		TOTAL NUMBER OF CLAIMS	240

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 01/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,803.17	0.00	OTHER LAB	1,672.65	0.00
MED/SURG SUPPLY	147.49	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,003.45	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,950.85	2,425.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	62,385.75	13,948.35
EKG/ECG	1,296.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,543.58	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	275.10	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	192,888.29	702.74	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,876.39	244.25
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	258.30	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,406.05	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,768.20	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,494.80	0.00			
			TOTAL ANCILLARY	300,512.52	17,579.14
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	300,512.52	17,579.14

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

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

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 01/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,774.55	ADJUSTMENTS	0.00
COVERED CHARGES	4,743.05	CONTRACTUAL ALLOW	2,062.97
NON-COVERD CHARGES	31.50	TOTAL MEDICAID LIAB	2,680.08
		LESS: COB	2,674.08
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 01/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9.54	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	2,132.55	31.50
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	2,553.83	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	47.13	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,743.05	31.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,743.05	31.50

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

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

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 01/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	347,290.82	ADJUSTMENTS	16,572.69
COVERED CHARGES	294,250.82	CONTRACTUAL ALLOW	255,524.94
NON-COVERD CHARGES	53,040.00	TOTAL MEDICAID LIAB	38,725.88
		LESS: COB	0.00
		LESS: COPAYMENT	69.00
		REIMBURSEMENT	38,656.88

TOTAL NUMBER OF CLAIMS 7

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

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

PROVIDER NUMBER
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 01/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,740.76	775.08	OTHER LAB	745.50	0.00
MED/SURG SUPPLY	19,094.53	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,562.05	6,671.70	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,425.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,676.75	2,428.65
EKG/ECG	518.70	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	223.87	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	99,628.20	27,016.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	43,885.60	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	22,338.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,064.91	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,320.20	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	37,598.37	1,400.91
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	867.00	11,482.49
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,079.40	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,025.70	615.30			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,104.40	0.00			
			TOTAL ANCILLARY	294,250.82	53,040.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	294,250.82	53,040.00

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: 08/24/2017
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PRIME HEALTHCARE FOUNDATION-SOUTHERN REGIONAL LLC	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
11 UPPER RIVERDALE RD SW	000000404A	SERVICE DATES	07/01/15	THROUGH	01/31/16
RIVERDALE,GA 30274-2615		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: 08/24/2017
 Run Time: 02:28:14
 Page: 1

CLINCH MEMORIAL HOSP
 1050 VALDOSTA HWY
 HOMERVILLE,GA 31634-9701

PROVIDER NUMBER 000000415A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	169,157.31	ADJUSTMENTS	34,403.49
COVERED CHARGES	167,329.31	CONTRACTUAL ALLOW	76,317.66
NON-COVERD CHARGES	1,828.00	TOTAL MEDICAID LIAB	91,011.65
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	91,011.65

TOTAL NUMBER OF ADMISSIONS 17

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	40		0	16,000.00		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	40		0	16,000.00		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	40		0	16,000.00		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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	61,223.38	0.00	OTHER LAB	327.00	0.00
MED/SURG SUPPLY	15,624.74	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	31,809.19	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,359.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,707.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	255.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	10,349.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	280.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,037.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,038.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	360.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,840.00	1,548.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	400.00	0.00			
			TOTAL ANCILLARY	151,329.31	1,828.00
			TOTAL ACCOMODATIONS	16,000.00	0.00
			TOTAL CHARGES	167,329.31	1,828.00

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 07/01/15 THROUGH 06/30/16
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: 08/24/2017
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Page: 4

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	598,296.09	ADJUSTMENTS	1,187.12
COVERED CHARGES	551,137.95	CONTRACTUAL ALLOW	265,083.18
NON-COVERD CHARGES	47,158.14	TOTAL MEDICAID LIAB	286,054.77
		LESS: COB	1,000.00
		LESS: COPAYMENT	744.00
		REIMBURSEMENT	284,310.77
		ALL OTHER	258,581.82
		FEE SCHEDULE-LAB	25,728.95
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 796

CLINCH MEMORIAL HOSP
 1050 VALDOSTA HWY
 HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
 000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	49,047.61	0.00	OTHER LAB	1,612.00	0.00
MED/SURG SUPPLY	23,344.14	359.14	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	71.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	29,062.00	234.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	84,822.00	12,039.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,238.00	1,109.00	FEE SCHEDULE LAB	201,114.20	12,147.00
EKG/ECG	21,353.00	7,530.00	MRI SERVICES	4,050.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	927.00
OPERATING ROOM	2,963.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,252.00	2,138.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	96,128.00	7,985.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	336.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,455.00	340.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	736.00	774.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,166.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	6,810.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,649.00	1,505.00			
			TOTAL ANCILLARY	551,137.95	47,158.14
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	551,137.95	47,158.14

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

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,322.29	ADJUSTMENTS	0.00
COVERED CHARGES	1,322.29	CONTRACTUAL ALLOW	267.70
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1,054.59
		LESS: COB	1,054.59
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 4

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	262.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	80.59	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	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	248.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	617.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,322.29	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,322.29	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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	56,386.15	ADJUSTMENTS	47.00
COVERED CHARGES	55,008.47	CONTRACTUAL ALLOW	48,063.47
NON-COVERD CHARGES	1,377.68	TOTAL MEDICAID LIAB	6,945.00
		LESS: COB	0.00
		LESS: COPAYMENT	273.00
		REIMBURSEMENT	6,672.00
		TOTAL NUMBER OF CLAIMS	139

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,041.40	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	753.57	61.68	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,280.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,932.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,572.00	623.00
EKG/ECG	486.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	332.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,619.00	693.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	992.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	55,008.47	1,377.68
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	55,008.47	1,377.68

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: 08/24/2017
Run Time: 02:28:29
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	408.70	ADJUSTMENTS	0.00
COVERED CHARGES	208.70	CONTRACTUAL ALLOW	-63.84
NON-COVERD CHARGES	200.00	TOTAL MEDICAID LIAB	272.54
		LESS: COB	266.54
		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

CLINCH MEMORIAL HOSP
 1050 VALDOSTA HWY
 HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
 000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	200.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	204.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	208.70	200.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	208.70	200.00

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

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,618.14	ADJUSTMENTS	0.00
COVERED CHARGES	18,120.14	CONTRACTUAL ALLOW	6,549.90
NON-COVERD CHARGES	498.00	TOTAL MEDICAID LIAB	11,570.24
		LESS: COB	3,975.08
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,595.16

TOTAL NUMBER OF CLAIMS 2

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,289.30	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	559.84	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	150.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,191.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,114.00	141.00
EKG/ECG	162.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	479.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,075.00	287.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	9,000.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	100.00	70.00			
			TOTAL ANCILLARY	18,120.14	498.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,120.14	498.00

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: 08/24/2017
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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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	85,559,466.72	ADJUSTMENTS	3,858,666.63
COVERED CHARGES	82,323,885.89	CONTRACTUAL ALLOW	66,055,196.53
NON-COVERD CHARGES	3,235,580.83	TOTAL MEDICAID LIAB	16,268,689.36
		LESS: COB	158,387.69
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	16,110,301.67

TOTAL NUMBER OF ADMISSIONS 2,411

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7,742		21	8,970,084.00		2,817,567.00
ROUTINE NURSERY	1,288		2	1,793,296.00		45,856.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	9,030		23	10,763,380.00		2,863,423.00
SPECIAL CARE SERVICES						
CCU	2,471		0	5,661,658.00		18,360.00
ICU	700		0	2,299,728.00		0.00
NICU	568		0	1,791,848.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	8		0	37,256.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	3,747		0	9,790,490.00		18,360.00
TOTAL ACCOMODATIONS	12,777		23	20,553,870.00		2,881,783.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,466,713.41	71,971.95	OTHER LAB	743,462.00	5,549.00
MED/SURG SUPPLY	2,480,202.67	28,802.88	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,862,014.26	19,597.00	EDUCATION & TRAINING	69,391.00	0.00
RADIOLOGY-DIAGNOSTIC	1,579,471.00	3,160.00	OTHER THERAPEUTIC SVC	0.00	8,884.00
CT SCAN	4,039,040.00	6,237.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	694,117.39	16,229.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	649,044.00	894.00	MRI SERVICES	1,093,471.00	0.00
IV THERAPY	939,702.00	8,974.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,678,012.00	15,236.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,863,268.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,091,346.00	50,797.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,543,067.00	14,992.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,078,426.00	4,408.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,111,805.00	8,974.00	DRUG-SPECIFIC/HOME IV	0.00	1,650.50
LABORATORY PATHOLOGIC	393,542.00	614.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	67,488.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	411,047.81	13,053.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	206,200.29	840.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	2,133,500.00	23,952.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	98,457.00	13,344.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	417,262.00	0.00	IMPL DEV CHARGE PATIENTS	1,187,131.61	7,114.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	17,060.00
OTHER IMAGING SERVICE	634,862.00	1,282.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	870,811.00	8,880.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	558,595.00	371.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,249,596.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	200,669.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	358,301.45	931.00			
			TOTAL ANCILLARY	61,770,015.89	353,797.83
			TOTAL ACCOMODATIONS	20,553,870.00	2,881,783.00
			TOTAL CHARGES	82,323,885.89	3,235,580.83

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

PROVIDER NUMBER
 000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5215362002599	07/11/15 - 07/20/15	02/22/16	0.00	3,414.00	0.00	0.00	0.00
905	5215362009014	08/14/15 - 08/18/15	02/22/16	0.00	758.00	0.00	0.00	0.00
905	5215362009015	08/14/15 - 08/17/15	02/22/16	0.00	758.00	0.00	0.00	0.00
905	5215362011544	08/12/15 - 08/19/15	02/22/16	0.00	758.00	0.00	0.00	0.00
905	5215362013500	08/24/15 - 08/31/15	02/22/16	0.00	758.00	0.00	0.00	0.00
905	5215362015317	08/31/15 - 09/08/15	02/22/16	0.00	758.00	0.00	0.00	0.00
905	5215362015318	09/02/15 - 09/08/15	02/22/16	0.00	758.00	0.00	0.00	0.00
905	5215362015319	09/04/15 - 09/09/15	02/22/16	0.00	758.00	0.00	0.00	0.00
905	5215362015321	09/04/15 - 09/08/15	02/22/16	0.00	758.00	0.00	0.00	0.00
905	5215362017734	09/10/15 - 09/14/15	02/22/16	0.00	1,516.00	0.00	0.00	0.00
905	5215362019244	09/09/15 - 09/21/15	02/22/16	0.00	1,516.00	0.00	0.00	0.00
905	5215362021232	09/19/15 - 09/22/15	02/22/16	0.00	758.00	0.00	0.00	0.00
905	5215362022069	09/11/15 - 09/18/15	02/22/16	0.00	758.00	0.00	0.00	0.00
905	5215363001701	09/29/15 - 10/05/15	02/22/16	0.00	758.00	0.00	0.00	0.00
905	5215363001995	10/02/15 - 10/06/15	02/22/16	0.00	758.00	0.00	0.00	0.00
905	5216139020251	02/02/16 - 02/05/16	05/30/16	0.00	1,518.00	0.00	0.00	0.00
TOTAL				0.00	17,060.00	0.00	0.00	0.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,561,735.72	ADJUSTMENTS	0.00
COVERED CHARGES	1,538,783.22	CONTRACTUAL ALLOW	902,172.74
NON-COVERD CHARGES	22,952.50	TOTAL MEDICAID LIAB	636,610.48
		LESS: COB	636,610.48
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 51

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	87		0	99,535.00		12,045.00
ROUTINE NURSERY	71		0	138,396.00		95.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	158		0	237,931.00		12,140.00
SPECIAL CARE SERVICES						
CCU	42		0	96,390.00		0.00
ICU	12		0	39,348.00		0.00
NICU	10		0	31,250.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	64		0	166,988.00		0.00
TOTAL ACCOMODATIONS	222		0	404,919.00		12,140.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	193,043.00	385.50	OTHER LAB	15,529.00	0.00
MED/SURG SUPPLY	55,788.28	247.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	186,856.76	455.00	EDUCATION & TRAINING	5,488.00	184.00
RADIOLOGY-DIAGNOSTIC	14,430.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	32,855.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,556.03	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,493.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	11,770.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	82,857.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	207,813.00	9,148.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	52,164.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	27,292.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,722.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	27,575.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	7,273.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,168.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	833.03	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	21,788.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,887.00	111.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	958.00	0.00	IMPL DEV CHARGE PATIENTS	17,889.16	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,317.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,440.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	18,546.00	282.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	81,142.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,390.96	0.00			
			TOTAL ANCILLARY	1,133,864.22	10,812.50
			TOTAL ACCOMODATIONS	404,919.00	12,140.00
			TOTAL CHARGES	1,538,783.22	22,952.50

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: 08/24/2017
Run Time: 02:29:22
Page: 6

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

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	31,331,905.18	ADJUSTMENTS	339,087.43
COVERED CHARGES	27,823,727.76	CONTRACTUAL ALLOW	23,884,766.67
NON-COVERD CHARGES	3,508,177.42	TOTAL MEDICAID LIAB	3,938,961.09
		LESS: COB	41,246.53
		LESS: COPAYMENT	6,154.54
		REIMBURSEMENT	3,891,560.02
		ALL OTHER	3,399,602.19
		FEE SCHEDULE-LAB	396,294.29
		INJECTABLE DRUGS	95,663.54
		TOTAL NUMBER OF CLAIMS	10,147

SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER
 000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	595,203.43	13,623.25	OTHER LAB	665,599.00	0.00
MED/SURG SUPPLY	685,817.54	71,505.64	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,336.28	EDUCATION & TRAINING	0.00	184.00
RADIOLOGY-DIAGNOSTIC	1,530,657.00	4,353.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,324,170.00	730,732.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	44,781.00	30,890.02	FEE SCHEDULE LAB	4,793,669.66	244,596.10
EKG/ECG	528,103.00	14,751.00	MRI SERVICES	595,994.00	178,749.00
IV THERAPY	1,358,471.00	1,779.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,934,226.00	373,362.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	205,936.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	105,679.00	102,958.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	891,980.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,235.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,572,431.00	3,412.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	720,944.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	561,053.68	680,649.25
RADIOLOGY THERAPEUTIC	3,960.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	24,931.00	11,612.06	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,202.00	7,780.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	143,712.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	349,972.00	16,013.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	168,664.00	132,320.00	IMPL DEV CHARGE PATIENTS	128,905.78	74,984.24
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,589.00
OTHER IMAGING SERVICE	785,801.00	323,018.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	107,883.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	297,069.00	160,933.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	409,257.00	178,229.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	10,336.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	413,796.67	4,106.58			
			TOTAL ANCILLARY	27,823,727.76	3,508,177.42
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	27,823,727.76	3,508,177.42

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: 08/24/2017
Run Time: 02:29:22
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
35	5916011000176	12/10/15 - 12/10/15	01/18/16	0.00	18.00	0.00	0.00	0.00
616	2016042047744	02/02/16 - 02/02/16	02/15/16	0.00	2,571.00	0.00	0.00	0.00
TOTAL				0.00	2,589.00	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: 08/24/2017
Run Time: 02:31:23
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	635,665.65	ADJUSTMENTS	0.00
COVERED CHARGES	495,769.76	CONTRACTUAL ALLOW	317,270.09
NON-COVERD CHARGES	139,895.89	TOTAL MEDICAID LIAB	178,499.67
		LESS: COB	178,438.25
		LESS: COPAYMENT	61.42
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 136

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,835.50	780.00	OTHER LAB	25,237.00	0.00
MED/SURG SUPPLY	24,764.48	154.44	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,340.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,444.00	44,008.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	87,560.48	3,030.64
EKG/ECG	6,705.00	0.00	MRI SERVICES	4,517.00	0.00
IV THERAPY	25,392.00	0.00	PROFESSIONAL FEES	0.00	147.00
OPERATING ROOM	34,361.00	52,430.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,352.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	278.00	944.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	38,488.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	125,432.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	29,581.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,154.75	3,559.25
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	6,944.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,110.00	555.00	IMPL DEV CHARGE PATIENTS	199.44	310.56
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,889.00	25,478.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	6,576.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,655.00	1,923.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,530.11	0.00			
			TOTAL ANCILLARY	495,769.76	139,895.89
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	495,769.76	139,895.89

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

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,398,714.31	ADJUSTMENTS	820.91
COVERED CHARGES	1,324,246.06	CONTRACTUAL ALLOW	1,282,089.76
NON-COVERD CHARGES	74,468.25	TOTAL MEDICAID LIAB	42,156.30
		LESS: COB	313.18
		LESS: COPAYMENT	1,020.15
		REIMBURSEMENT	40,822.97
		TOTAL NUMBER OF CLAIMS	748

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,948.50	435.00	OTHER LAB	52,136.00	0.00
MED/SURG SUPPLY	3,662.00	713.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	62,834.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	75,342.00	19,052.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	252,025.00	15,480.00
EKG/ECG	19,221.00	0.00	MRI SERVICES	4,678.00	0.00
IV THERAPY	60,628.00	494.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,404.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,303.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,134.00	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	698,237.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,715.50	1,012.25
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	232.00	444.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	4,830.00	9,990.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	45,015.00	17,434.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	9,414.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,122.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,779.06	0.00			
			TOTAL ANCILLARY	1,324,246.06	74,468.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,324,246.06	74,468.25

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: 08/24/2017
Run Time: 02:31:35
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	34,118.00	ADJUSTMENTS	0.00
COVERED CHARGES	25,865.00	CONTRACTUAL ALLOW	19,469.84
NON-COVERD CHARGES	8,253.00	TOTAL MEDICAID LIAB	6,395.16
		LESS: COB	6,374.16
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	12

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,049.00	0.00	OTHER LAB	1,799.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	6,154.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,616.00	295.00
EKG/ECG	0.00	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	12,968.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	431.00	555.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	746.00	1,249.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	25,865.00	8,253.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,865.00	8,253.00

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,225,063.98	ADJUSTMENTS	66,360.54
COVERED CHARGES	2,167,665.87	CONTRACTUAL ALLOW	1,871,224.56
NON-COVERD CHARGES	57,398.11	TOTAL MEDICAID LIAB	296,441.31
		LESS: COB	0.00
		LESS: COPAYMENT	264.00
		REIMBURSEMENT	296,177.31
		TOTAL NUMBER OF CLAIMS	54

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	60,092.25	720.00	OTHER LAB	264.00	0.00
MED/SURG SUPPLY	83,241.28	3,522.36	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,347.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	676.00	FEE SCHEDULE LAB	35,258.00	1,176.00
EKG/ECG	447.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	57,034.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	259,381.00	17,601.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,232.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	84,899.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	70,000.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	993,212.35	28,213.75
RADIOLOGY THERAPEUTIC	7,128.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,671.00	111.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	268,557.52	680.00
LITHOTRIPSY	198,805.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,760.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	22,730.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	240.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	3,253.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,606.47	1,205.00			
			TOTAL ANCILLARY	2,167,665.87	57,398.11
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,167,665.87	57,398.11

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: 08/24/2017
Run Time: 02:31:41
Page: 17

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	70,597.75	ADJUSTMENTS	0.00
COVERED CHARGES	30,613.75	CONTRACTUAL ALLOW	-24,097.41
NON-COVERD CHARGES	39,984.00	TOTAL MEDICAID LIAB	54,711.16
		LESS: COB	54,705.16
		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: 08/24/2017
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 Page: 18

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	510.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	172.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	457.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,484.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	25,795.25	39,984.00
RADIOLOGY THERAPEUTIC	594.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	601.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	30,613.75	39,984.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	30,613.75	39,984.00

** 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
 SUMMARY TYPE I
 INPATIENT PAID CLAIMS

Run Date: 08/24/2017
 Run Time: 04:12:03
 Page: 1

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

PROVIDER NUMBER 000000437A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 06/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,216,398.17	ADJUSTMENTS	294,544.78
COVERED CHARGES	2,204,859.17	CONTRACTUAL ALLOW	1,223,391.75
NON-COVERD CHARGES	11,539.00	TOTAL MEDICAID LIAB	981,467.42
		LESS: COB	10,636.72
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	970,830.70

TOTAL NUMBER OF ADMISSIONS 186

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	343		0	150,577.00		439.00
ROUTINE NURSERY	83		0	20,418.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	426		0	170,995.00		439.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	139		0	138,491.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	139		0	138,491.00		0.00
TOTAL ACCOMODATIONS	565		0	309,486.00		439.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 06/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	182,610.68	0.00	OTHER LAB	11,786.00	0.00
MED/SURG SUPPLY	135,628.29	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	276,401.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	32,440.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	164,719.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	25,675.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	16,800.00	0.00	MRI SERVICES	16,021.00	0.00
IV THERAPY	20,619.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	89,231.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	95,050.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	175,164.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	12,833.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	120,967.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,357.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	4,755.00	0.00	INJECTABLE DRUGS	345,104.20	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	4,220.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	62,920.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	10,402.00
OTHER IMAGING SERVICE	11,659.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,552.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,277.00	698.00			
AUDIOLOGY	423.00	0.00			
CARDIOLOGY	34,135.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	965.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	33,061.00	0.00			
			TOTAL ANCILLARY	1,895,373.17	11,100.00
			TOTAL ACCOMODATIONS	309,486.00	439.00
			TOTAL CHARGES	2,204,859.17	11,539.00

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

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

Run Date: 08/24/2017
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SUMMARY TYPE I
INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5215362005982	07/24/15 - 07/28/15	02/22/16	0.00	1,985.00	0.00	0.00	0.00
614	2016140058211	05/10/16 - 05/13/16	05/23/16	0.00	2,147.00	0.00	0.00	0.00
615	5916146000941	03/04/16 - 03/05/16	05/30/16	0.00	4,285.00	0.00	0.00	0.00
615	2016189039156	06/20/16 - 06/28/16	07/11/16	0.00	1,985.00	0.00	0.00	0.00
TOTAL				0.00	10,402.00	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: 08/24/2017
 Run Time: 04:12:05
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SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 06/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	37,739.91	ADJUSTMENTS	0.00
COVERED CHARGES	37,726.91	CONTRACTUAL ALLOW	13,419.42
NON-COVERD CHARGES	13.00	TOTAL MEDICAID LIAB	24,307.49
		LESS: COB	24,307.49
		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	3,073.00		0.00
ROUTINE NURSERY	1		0	439.00		13.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	8		0	3,512.00		13.00
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	10		0	5,610.00		13.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 06/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,263.91	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,811.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,097.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	171.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,192.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,406.00	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	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,345.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,857.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,605.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,407.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	305.00	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	32,116.91	0.00
			TOTAL ACCOMODATIONS	5,610.00	13.00
			TOTAL CHARGES	37,726.91	13.00

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: 08/24/2017
Run Time: 04:12:05
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ST MARYS SACRED HEART HOSPITAL INC
367 CLEAR CREEK PARKWAY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,989,361.81	ADJUSTMENTS	96,347.71
COVERED CHARGES	3,665,716.77	CONTRACTUAL ALLOW	2,523,774.40
NON-COVERD CHARGES	323,645.04	TOTAL MEDICAID LIAB	1,141,942.37
		LESS: COB	564.33
		LESS: COPAYMENT	2,216.47
		REIMBURSEMENT	1,139,161.57
		ALL OTHER	1,041,167.37
		FEE SCHEDULE-LAB	85,059.69
		INJECTABLE DRUGS	12,934.51

TOTAL NUMBER OF CLAIMS 2,581

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

PROVIDER NUMBER
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 06/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	46,072.18	9,425.25	OTHER LAB	20,393.00	0.00
MED/SURG SUPPLY	88,337.15	31,581.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,155.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	201,969.00	2,439.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	632,149.00	51,365.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,183.00	12,613.00	FEE SCHEDULE LAB	698,649.24	35,088.00
EKG/ECG	50,479.00	0.00	MRI SERVICES	113,287.00	0.00
IV THERAPY	198,918.00	2,173.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	104,800.00	10,852.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	795.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	59,364.00	9,453.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1.00	419.00	AMBULANCE	0.00	0.00
GI SERVICES	162,004.50	11,598.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	808,210.00	1,605.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,014.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	150,847.70	81,801.54
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	2,517.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	5,110.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,117.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,985.00
OTHER IMAGING SERVICE	83,443.00	4,449.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,365.00	5,245.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	69,492.00	37,072.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	44,495.00	5,348.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	33,464.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	62,868.00	350.00			
			TOTAL ANCILLARY	3,665,716.77	323,645.04
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,665,716.77	323,645.04

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: 08/24/2017
Run Time: 04:12:05
Page: 8

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

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016064070159	02/22/16 - 02/22/16	03/07/16	0.00	1,985.00	0.00	0.00	0.00
TOTAL				0.00	1,985.00	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: 08/24/2017
Run Time: 04:12:17
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	51,153.24	ADJUSTMENTS	0.00
COVERED CHARGES	38,677.24	CONTRACTUAL ALLOW	9,224.13
NON-COVERD CHARGES	12,476.00	TOTAL MEDICAID LIAB	29,453.11
		LESS: COB	29,429.37
		LESS: COPAYMENT	23.74
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 43

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

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

PROVIDER NUMBER
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 06/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	93.44	80.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	94.00	453.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,703.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,116.00	7,420.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	15,273.00	1,163.00
EKG/ECG	320.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,636.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,750.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,545.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,280.80	188.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,279.00	1,422.00			
BLOOD	0.00	0.00			
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	38,677.24	12,476.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	38,677.24	12,476.00

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: 08/24/2017
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ST MARYS SACRED HEART HOSPITAL INC
367 CLEAR CREEK PARKWAY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	289,624.40	ADJUSTMENTS	211.76
COVERED CHARGES	282,271.40	CONTRACTUAL ALLOW	262,468.64
NON-COVERD CHARGES	7,353.00	TOTAL MEDICAID LIAB	19,802.76
		LESS: COB	3.44
		LESS: COPAYMENT	680.66
		REIMBURSEMENT	19,118.66
		TOTAL NUMBER OF CLAIMS	354

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

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

Run Date: 08/24/2017
 Run Time: 04:12:18
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SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 06/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,360.00	90.00	OTHER LAB	1,150.00	0.00
MED/SURG SUPPLY	465.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,065.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	52,883.00	2,518.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	182.00	FEE SCHEDULE LAB	47,879.00	961.00
EKG/ECG	2,400.00	0.00	MRI SERVICES	1,472.00	0.00
IV THERAPY	12,441.00	148.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,030.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	136,377.00	106.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,169.40	3,202.00
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	146.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	580.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	282,271.40	7,353.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	282,271.40	7,353.00

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: 08/24/2017
Run Time: 04:12:20
Page: 13

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

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,616.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,586.00	CONTRACTUAL ALLOW	1,682.12
NON-COVERD CHARGES	30.00	TOTAL MEDICAID LIAB	1,903.88
		LESS: COB	1,897.88
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 06/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 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	1,057.00	30.00
EKG/ECG	160.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,609.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	49.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL 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	3,586.00	30.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,586.00	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

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

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	43,101.00	ADJUSTMENTS	0.00
COVERED CHARGES	37,739.00	CONTRACTUAL ALLOW	26,633.48
NON-COVERD CHARGES	5,362.00	TOTAL MEDICAID LIAB	11,105.52
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	11,105.52

TOTAL NUMBER OF CLAIMS 2

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

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

PROVIDER NUMBER
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 06/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	708.00	722.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	12,257.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	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	2,499.00	0.00
EKG/ECG	320.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,892.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	657.00	1,647.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,864.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,223.00	2,295.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,277.00	698.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	710.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,920.00	0.00			
			TOTAL ANCILLARY	37,739.00	5,362.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	37,739.00	5,362.00

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: 08/24/2017
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER
000000437A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	06/01/15	THROUGH	06/30/16
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: 08/24/2017
 Run Time: 02:31:50
 Page: 1

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,319,940.08	ADJUSTMENTS	330,307.01
COVERED CHARGES	10,071,857.08	CONTRACTUAL ALLOW	6,899,690.36
NON-COVERD CHARGES	248,083.00	TOTAL MEDICAID LIAB	3,172,166.72
		LESS: COB	65,855.57
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,106,311.15

TOTAL NUMBER OF ADMISSIONS 422

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,261	0	884,269.00	40,604.00
ROUTINE NURSERY	81	0	56,943.00	560.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,342	0	941,212.00	41,164.00
SPECIAL CARE SERVICES				
CCU	1	0	1,692.75	0.00
ICU	370	0	488,478.00	0.00
NICU	3	0	2,340.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	374	0	492,510.75	0.00
TOTAL ACCOMODATIONS	1,716	0	1,433,722.75	41,164.00

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

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

Run Date: 08/24/2017
 Run Time: 02:31:50
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,186,611.38	0.00	OTHER LAB	46,232.00	0.00
MED/SURG SUPPLY	518,796.22	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,073,202.79	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	192,483.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	479,110.00	49,240.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	82,241.59	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	256,632.00	0.00	MRI SERVICES	121,413.00	0.00
IV THERAPY	192,824.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	839,381.00	5,663.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	44,982.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	720,969.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	135,193.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	81,801.00	3,006.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	277,707.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	42,504.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	60,000.00
LABORATORY PATHOLOGIC	16,946.00	0.00	INJECTABLE DRUGS	208,424.22	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,656.23	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	59,670.00	2,280.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,871.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	334,020.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	19,189.00
OTHER IMAGING SERVICE	36,277.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	20,540.00	66,087.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	56,369.00	1,454.00			
AUDIOLOGY	9,635.00	0.00			
CARDIOLOGY	421,242.75	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	14,336.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	163,063.90	0.00			
			TOTAL ANCILLARY	8,638,134.33	206,919.00
			TOTAL ACCOMODATIONS	1,433,722.75	41,164.00
			TOTAL CHARGES	10,071,857.08	248,083.00

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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016222074086	07/30/16 - 08/03/16	08/15/16	0.00	2,803.00	0.00	0.00	0.00
615	2016274129592	01/19/16 - 02/05/16	10/10/16	0.00	2,695.00	0.00	0.00	0.00
615	2016281066884	05/18/16 - 05/25/16	10/17/16	0.00	2,695.00	0.00	0.00	0.00
615	2316321000318	08/28/16 - 08/31/16	12/12/16	0.00	5,498.00	0.00	2,581.86	0.00
615	2017102066980	07/24/16 - 07/26/16	04/17/17	0.00	5,498.00	0.00	0.00	0.00
TOTAL				0.00	19,189.00	0.00	2,581.86	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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	101,053.00	ADJUSTMENTS	0.00
COVERED CHARGES	100,551.00	CONTRACTUAL ALLOW	44,992.48
NON-COVERD CHARGES	502.00	TOTAL MEDICAID LIAB	55,558.52
		LESS: COB	55,558.52
		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	14		0	9,842.00		502.00
ROUTINE NURSERY	8		0	5,624.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	22		0	15,466.00		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	22		0	15,466.00		502.00

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

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,018.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	13,503.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,393.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	718.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,742.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	414.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,201.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	35,435.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	539.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	949.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,960.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,576.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,135.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	797.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	705.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	85,085.00	0.00
			TOTAL ACCOMODATIONS	15,466.00	502.00
			TOTAL CHARGES	100,551.00	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: 08/24/2017
Run Time: 02:32:00
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,311,842.54	ADJUSTMENTS	522,665.90
COVERED CHARGES	10,817,194.61	CONTRACTUAL ALLOW	9,041,760.95
NON-COVERD CHARGES	494,647.93	TOTAL MEDICAID LIAB	1,775,433.66
		LESS: COB	9,888.14
		LESS: COPAYMENT	4,385.04
		REIMBURSEMENT	1,761,160.48
		ALL OTHER	1,580,734.78
		FEE SCHEDULE-LAB	161,987.86
		INJECTABLE DRUGS	18,437.84
		TOTAL NUMBER OF CLAIMS	4,613

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	484,079.00	274.00	OTHER LAB	68,922.00	377.00
MED/SURG SUPPLY	351,857.99	10,971.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,441.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	422,999.99	2,847.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,136,547.99	71,614.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	50,114.00	8,881.00	FEE SCHEDULE LAB	2,019,210.95	100,234.99
EKG/ECG	175,244.00	1,118.00	MRI SERVICES	275,355.00	5,514.00
IV THERAPY	723,327.00	14,579.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,587,529.00	25,787.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	13,995.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	168,564.98	9,252.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	328,894.00	3,073.00	AMBULANCE	0.00	0.00
GI SERVICES	153,223.00	17,460.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,437,404.10	3,563.02	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	80,500.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	126,835.00	25,341.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,058.00	294.21	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	760.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	109,135.00	2,523.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	30,993.00	101,951.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	155,539.00	12,962.99			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,192.00	14,448.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	306,386.00	11,433.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	127,663.00	15,389.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	53,904.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	422,721.61	32,559.72			
			TOTAL ANCILLARY	10,817,194.61	494,647.93
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,817,194.61	494,647.93

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

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	196,387.24	ADJUSTMENTS	0.00
COVERED CHARGES	162,746.28	CONTRACTUAL ALLOW	69,112.97
NON-COVERD CHARGES	33,640.96	TOTAL MEDICAID LIAB	93,633.31
		LESS: COB	93,577.61
		LESS: COPAYMENT	55.70
		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

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,502.00	0.00	OTHER LAB	1,528.00	0.00
MED/SURG SUPPLY	7,395.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	999.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,733.00	180.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,480.00	3,099.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,504.00	0.00	FEE SCHEDULE LAB	28,635.99	2,187.00
EKG/ECG	1,737.00	0.00	MRI SERVICES	11,028.00	0.00
IV THERAPY	12,020.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	25,981.00	16,157.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,575.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,002.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,221.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,763.01	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,932.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	436.00	1,146.00
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	4,336.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,653.00	2,741.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,926.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,358.28	6,351.96			
			TOTAL ANCILLARY	162,746.28	32,860.96
			TOTAL ACCOMODATIONS	0.00	780.00
			TOTAL CHARGES	162,746.28	33,640.96

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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	474,925.16	ADJUSTMENTS	914.98
COVERED CHARGES	459,579.16	CONTRACTUAL ALLOW	432,224.45
NON-COVERD CHARGES	15,346.00	TOTAL MEDICAID LIAB	27,354.71
		LESS: COB	6.50
		LESS: COPAYMENT	727.88
		REIMBURSEMENT	26,620.33
		TOTAL NUMBER OF CLAIMS	494

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,341.00	7.00	OTHER LAB	1,236.00	0.00
MED/SURG SUPPLY	3,395.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	30,271.00	508.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	41,278.00	6,444.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	104,452.96	3,851.00
EKG/ECG	4,631.99	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	27,952.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	279.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,898.00	148.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	878.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	215,556.05	370.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,434.00	113.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	87.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,484.00	876.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	136.00	2,064.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,234.16	0.00			
			TOTAL ANCILLARY	459,579.16	15,346.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	459,579.16	15,346.00

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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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,305.00	ADJUSTMENTS	0.00
COVERED CHARGES	7,253.00	CONTRACTUAL ALLOW	3,795.23
NON-COVERD CHARGES	52.00	TOTAL MEDICAID LIAB	3,457.77
		LESS: COB	3,457.73
		LESS: COPAYMENT	0.04
		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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	745.00	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	1,962.96	52.00
EKG/ECG	193.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	487.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,427.04	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	438.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,253.00	52.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,253.00	52.00

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

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,546,615.08	ADJUSTMENTS	55,419.30
COVERED CHARGES	1,433,020.08	CONTRACTUAL ALLOW	1,250,027.49
NON-COVERD CHARGES	113,595.00	TOTAL MEDICAID LIAB	182,992.59
		LESS: COB	0.00
		LESS: COPAYMENT	111.00
		REIMBURSEMENT	182,881.59
		TOTAL NUMBER OF CLAIMS	33

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,732.00	0.00	OTHER LAB	1,300.00	0.00
MED/SURG SUPPLY	23,779.00	6,045.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,551.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,185.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	3,230.00	FEE SCHEDULE LAB	12,107.00	572.00
EKG/ECG	1,158.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,232.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	742,423.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,570.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	54,782.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,409.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	15,456.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,608.00	59.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	282,649.00	100,653.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	249,079.08	3,036.00			
			TOTAL ANCILLARY	1,433,020.08	113,595.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,433,020.08	113,595.00

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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	69,254.03	ADJUSTMENTS	0.00
COVERED CHARGES	68,885.00	CONTRACTUAL ALLOW	26,942.10
NON-COVERD CHARGES	369.03	TOTAL MEDICAID LIAB	41,942.90
		LESS: COB	41,936.90
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COFFEE REGIONAL MEDICAL CENTER
 1101 OCILLA RD
 DOUGLAS, GA 31533-2207

PROVIDER NUMBER
 000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,316.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	354.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	343.03	FEE SCHEDULE LAB	64.00	26.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	63,320.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	73.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,990.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	644.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	124.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	68,885.00	369.03
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	68,885.00	369.03

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

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

Run Date: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	47,218,929.92	ADJUSTMENTS	2,118,739.69
COVERED CHARGES	43,349,103.17	CONTRACTUAL ALLOW	34,645,824.63
NON-COVERD CHARGES	3,869,826.75	TOTAL MEDICAID LIAB	8,703,278.54
		LESS: COB	95,302.98
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,607,975.56

TOTAL NUMBER OF ADMISSIONS 1,096

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	4,910		0	4,632,928.00		3,322,856.00
ROUTINE NURSERY	97		0	80,449.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5,007		0	4,713,377.00		3,322,856.00
SPECIAL CARE SERVICES						
CCU	168		0	255,159.00		0.00
ICU	864		0	2,284,986.00		0.00
NICU	393		0	1,597,864.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	52		0	152,872.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,477		0	4,290,881.00		0.00
TOTAL ACCOMODATIONS	6,484		0	9,004,258.00		3,322,856.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,837,157.22	2,071.75	OTHER LAB	194,049.25	0.00
MED/SURG SUPPLY	1,516,011.00	1,591.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,187,096.75	9,654.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,330,162.50	625.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,877,142.50	430,943.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	820,884.51	1,899.50	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	223,894.50	0.00	MRI SERVICES	552,062.75	0.00
IV THERAPY	31,335.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,354,716.69	4,086.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	181,521.25	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,496,416.00	4,379.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	532,059.67	0.00	AMBULANCE	0.00	0.00
GI SERVICES	216,432.25	5,745.75	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,067,332.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	453,394.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	62,642.00
LABORATORY PATHOLOGIC	105,804.25	0.00	INJECTABLE DRUGS	7,061,520.28	9,760.50
RADIOLOGY THERAPEUTIC	21,676.75	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	669,119.56	1,243.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	211,303.99	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	148,376.50	2,257.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	9,178.50	178.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,666.00	2,801.25	IMPL DEV CHARGE PATIENTS	362,903.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	378,965.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	313,246.00	3,278.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	115,074.25	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,992,059.75	3,812.75			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	40,979.25	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	41,301.25	0.00			
			TOTAL ANCILLARY	34,344,845.17	546,970.75
			TOTAL ACCOMODATIONS	9,004,258.00	3,322,856.00
			TOTAL CHARGES	43,349,103.17	3,869,826.75

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	447,778.23	ADJUSTMENTS	0.00
COVERED CHARGES	446,475.23	CONTRACTUAL ALLOW	292,541.12
NON-COVERD CHARGES	1,303.00	TOTAL MEDICAID LIAB	153,934.11
		LESS: COB	153,934.11
		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	29		0	27,492.00		1,303.00
ROUTINE NURSERY	2		0	1,336.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	31		0	28,828.00		1,303.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	3		0	6,828.00		0.00
NICU	22		0	89,650.00		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	25		0	96,478.00		0.00
TOTAL ACCOMODATIONS	56		0	125,306.00		1,303.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,780.50	0.00	OTHER LAB	2,334.00	0.00
MED/SURG SUPPLY	9,159.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	42,042.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,629.25	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	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	44,556.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	59,331.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,909.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,263.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,440.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	43,287.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,443.00	0.00	INJECTABLE DRUGS	73,033.68	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	1,684.30	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	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,420.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,854.25	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	321,169.23	0.00
			TOTAL ACCOMODATIONS	125,306.00	1,303.00
			TOTAL CHARGES	446,475.23	1,303.00

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,598,523.60	ADJUSTMENTS	52,454.49
COVERED CHARGES	13,563,942.62	CONTRACTUAL ALLOW	12,327,698.25
NON-COVERD CHARGES	2,034,580.98	TOTAL MEDICAID LIAB	1,236,244.37
		LESS: COB	1,975.37
		LESS: COPAYMENT	1,530.47
		REIMBURSEMENT	1,232,738.53
		ALL OTHER	1,097,274.04
		FEE SCHEDULE-LAB	119,646.34
		INJECTABLE DRUGS	15,818.15

TOTAL NUMBER OF CLAIMS 4,108

COLISEUM MEDICAL CENTERS
 350 HOSPITAL DR
 MACON,GA 31217-3838

PROVIDER NUMBER
 000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	308,586.31	0.00	OTHER LAB	114,785.50	0.00
MED/SURG SUPPLY	254,027.00	941.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	11,880.75	EDUCATION & TRAINING	0.00	27.00
RADIOLOGY-DIAGNOSTIC	1,268,035.25	8,804.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,128,894.25	535,490.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	4,869.02	FEE SCHEDULE LAB	2,777,384.25	248,926.00
EKG/ECG	260,624.25	748.25	MRI SERVICES	107,029.75	47,223.00
IV THERAPY	453,439.50	508.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	759,157.97	260,556.26	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	19,494.75	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	57,326.25	9,636.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	308,687.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	223,013.62	54,261.88	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,225,541.25	9,070.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	230,244.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	136,763.06	97,784.32
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	670.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,056.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	2,956.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	3,425.75	IMPL DEV CHARGE PATIENTS	83,210.50	0.00
LITHOTRIPSY	7,744.25	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	357,322.00	199,299.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	24,246.75	9,931.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	65,353.00	47,659.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	285,823.75	478,855.25			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,187.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	104,020.41	0.00			
			TOTAL ANCILLARY	13,563,942.62	2,034,580.98
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,563,942.62	2,034,580.98

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	350,086.75	ADJUSTMENTS	0.00
COVERED CHARGES	295,733.50	CONTRACTUAL ALLOW	191,848.74
NON-COVERD CHARGES	54,353.25	TOTAL MEDICAID LIAB	103,884.76
		LESS: COB	103,842.76
		LESS: COPAYMENT	42.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 69

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,235.50	0.00	OTHER LAB	3,360.75	0.00
MED/SURG SUPPLY	5,386.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,394.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	39,390.00	20,719.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	60,295.25	2,045.00
EKG/ECG	4,704.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,346.25	686.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	48,676.25	17,440.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	792.00	295.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	365.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	24,241.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,009.75	3,009.75	CAST ROOM	0.00	0.00
EMERGENCY ROOM	48,894.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	27,013.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	674.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,257.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	60.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	84.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,071.50	3,770.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	4,069.75			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,798.00	0.00			
			TOTAL ANCILLARY	295,733.50	54,353.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	295,733.50	54,353.25

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	924,756.00	ADJUSTMENTS	382.58
COVERED CHARGES	830,403.50	CONTRACTUAL ALLOW	801,874.10
NON-COVERD CHARGES	94,352.50	TOTAL MEDICAID LIAB	28,529.40
		LESS: COB	0.00
		LESS: COPAYMENT	975.00
		REIMBURSEMENT	27,554.40
		TOTAL NUMBER OF CLAIMS	510

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,527.50	0.00	OTHER LAB	3,454.00	0.00
MED/SURG SUPPLY	733.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	84,569.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	71,634.00	60,037.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	172,049.50	27,114.75
EKG/ECG	8,694.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	24,734.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	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	1,072.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	432,050.50	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	3,840.00	2,445.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	60.50	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	6,410.50	2,878.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,567.75	1,337.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	781.25	479.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	830,403.50	94,352.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	830,403.50	94,352.50

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,482.00	ADJUSTMENTS	0.00
COVERED CHARGES	13,630.75	CONTRACTUAL ALLOW	8,477.73
NON-COVERD CHARGES	6,851.25	TOTAL MEDICAID LIAB	5,153.02
		LESS: COB	5,144.02
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	7

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	871.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	54.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	689.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	6,647.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,774.75	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	265.00	81.75	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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,899.75	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	76.00	122.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	13,630.75	6,851.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,630.75	6,851.25

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

COLISEUM MEDICAL CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,101,523.25	ADJUSTMENTS	0.00
COVERED CHARGES	1,070,260.50	CONTRACTUAL ALLOW	1,015,289.50
NON-COVERD CHARGES	31,262.75	TOTAL MEDICAID LIAB	54,971.00
		LESS: COB	0.00
		LESS: COPAYMENT	42.00
		REIMBURSEMENT	54,929.00
		TOTAL NUMBER OF CLAIMS	10

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,879.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	29,640.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,065.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,852.00	1,008.00
EKG/ECG	3,777.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	595,837.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	182.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,929.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,831.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,803.75	7,852.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	310,157.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	64,262.00	22,402.75			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,044.00	0.00			
			TOTAL ANCILLARY	1,070,260.50	31,262.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,070,260.50	31,262.75

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: 08/24/2017
Run Time: 02:34:23
Page: 15

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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
 Run Time: 03:59:42
 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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,383,215.01	ADJUSTMENTS	1,362,988.81
COVERED CHARGES	21,487,091.64	CONTRACTUAL ALLOW	15,524,401.72
NON-COVERD CHARGES	896,123.37	TOTAL MEDICAID LIAB	5,962,689.92
		LESS: COB	192,955.70
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,769,734.22

TOTAL NUMBER OF ADMISSIONS 581

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,525		0	1,044,514.00		492,441.00
ROUTINE NURSERY	318		0	229,032.00		206,448.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		1,790.00
TOTAL ROUTINE	1,843		0	1,273,546.00		700,679.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	661		0	1,543,420.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	661		0	1,543,420.00		0.00
TOTAL ACCOMODATIONS	2,504		0	2,816,966.00		700,679.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,919,821.96	46,141.70	OTHER LAB	199,290.00	0.00
MED/SURG SUPPLY	450,815.62	6,274.67	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,699,737.00	27,235.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	437,894.00	1,523.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,201,213.00	19,892.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	169,090.47	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	209,096.00	0.00	MRI SERVICES	270,383.00	8,928.00
IV THERAPY	11,176.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,505,368.00	21,760.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	341,376.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,797,967.00	1,482.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	229,476.00	2,152.00	AMBULANCE	0.00	0.00
GI SERVICES	170,500.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,445,969.00	4,808.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	411,977.00	2,999.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	68,768.00	508.00	INJECTABLE DRUGS	374.40	0.00
RADIOLOGY THERAPEUTIC	11,914.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	61,988.29	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	52,838.03	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	416,394.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	56,355.00	14,906.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	562,081.07	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	187,589.00	1,074.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	257,319.00	24,922.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	53,277.00	10,839.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	387,062.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	40,957.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	42,058.80	0.00			
			TOTAL ANCILLARY	18,670,125.64	195,444.37
			TOTAL ACCOMODATIONS	2,816,966.00	700,679.00
			TOTAL CHARGES	21,487,091.64	896,123.37

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	303,377.65	ADJUSTMENTS	0.00
COVERED CHARGES	288,658.65	CONTRACTUAL ALLOW	178,572.33
NON-COVERD CHARGES	14,719.00	TOTAL MEDICAID LIAB	110,086.32
		LESS: COB	110,086.32
		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	41		0	28,126.00		14,719.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	41		0	28,126.00		14,719.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	41		0	28,126.00		14,719.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT NEWNAN HOSPITAL INC	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
745 POPLAR ROAD	000000492A	SERVICE DATES	07/01/15	THROUGH	06/30/16
NEWNAN,GA 30265-1618		ADMISSION DATES	00/00/00	THROUGH	00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	52,907.89	0.00	OTHER LAB	3,446.00	0.00
MED/SURG SUPPLY	8,858.99	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	50,185.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,225.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,234.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,678.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	443.00	0.00	MRI SERVICES	7,681.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	33,753.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	26,834.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,622.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,756.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,145.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,400.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,016.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,644.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	884.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,689.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,838.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,967.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,325.00	0.00			
			TOTAL ANCILLARY	260,532.65	0.00
			TOTAL ACCOMODATIONS	28,126.00	14,719.00
			TOTAL CHARGES	288,658.65	14,719.00

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: 08/24/2017
Run Time: 03:59:49
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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,182,835.75	ADJUSTMENTS	602,398.73
COVERED CHARGES	18,455,899.72	CONTRACTUAL ALLOW	15,963,910.85
NON-COVERD CHARGES	2,726,936.03	TOTAL MEDICAID LIAB	2,491,988.87
		LESS: COB	58,035.33
		LESS: COPAYMENT	4,533.00
		REIMBURSEMENT	2,429,420.54
		ALL OTHER	2,163,109.50
		FEE SCHEDULE-LAB	160,333.59
		INJECTABLE DRUGS	105,977.45

TOTAL NUMBER OF CLAIMS 4,853

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	382,470.10	32,561.00	OTHER LAB	196,899.00	6,892.00
MED/SURG SUPPLY	284,220.42	15,584.54	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	841,043.00	13,530.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,567,456.00	559,670.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,678.00	10,964.33	FEE SCHEDULE LAB	3,078,733.00	146,175.00
EKG/ECG	372,042.00	27,466.00	MRI SERVICES	233,314.00	68,672.00
IV THERAPY	49,518.00	508.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	869,907.00	132,217.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	84,567.00	0.00	REHAB THERAPY	0.00	493.00
RESPIRATORY SERVICES	124,046.00	66,719.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	164,333.00	605.00	AMBULANCE	0.00	0.00
GI SERVICES	192,416.00	20,893.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,857,546.00	200,721.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	309,995.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	756,750.80	549,610.80
RADIOLOGY THERAPEUTIC	452,970.00	320,642.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	10,532.08	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	11,602.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	16,824.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	98,981.00	14,365.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	22,106.95	103,602.28
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	542,620.00	200,504.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	39,138.00	20,524.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	134,670.00	110,411.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	287,130.00	59,772.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	109,669.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	395,680.45	4,876.00			
			TOTAL ANCILLARY	18,455,899.72	2,726,936.03
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,455,899.72	2,726,936.03

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

Run Date: 08/24/2017
Run Time: 04:00:14
Page: 7

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	444,474.98	ADJUSTMENTS	0.00
COVERED CHARGES	342,715.61	CONTRACTUAL ALLOW	240,407.80
NON-COVERD CHARGES	101,759.37	TOTAL MEDICAID LIAB	102,307.81
		LESS: COB	102,219.24
		LESS: COPAYMENT	88.57
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 115

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,800.73	238.78	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,578.93	1,845.65	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,822.00	490.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,878.00	37,507.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	634.03	FEE SCHEDULE LAB	73,259.00	3,565.00
EKG/ECG	7,974.00	886.00	MRI SERVICES	4,060.00	9,419.00
IV THERAPY	1,130.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,168.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,455.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,402.00	1,682.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,252.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	7,658.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	135,742.00	3,850.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,389.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,400.35	14,009.91
RADIOLOGY THERAPEUTIC	8,236.00	620.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	820.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	566.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,197.00	442.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,396.00	16,865.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,346.00	2,385.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,934.00	5,934.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,637.60	0.00			
			TOTAL ANCILLARY	342,715.61	101,759.37
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	342,715.61	101,759.37

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	911,552.56	ADJUSTMENTS	1,565.26
COVERED CHARGES	835,257.66	CONTRACTUAL ALLOW	805,834.35
NON-COVERD CHARGES	76,294.90	TOTAL MEDICAID LIAB	29,423.31
		LESS: COB	6,171.27
		LESS: COPAYMENT	673.20
		REIMBURSEMENT	22,578.84
		TOTAL NUMBER OF CLAIMS	417

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

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

Run Date: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,611.35	265.20	OTHER LAB	6,314.00	0.00
MED/SURG SUPPLY	5,009.62	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	41,772.00	426.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	66,035.00	41,060.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	150,444.00	9,224.00
EKG/ECG	10,632.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,695.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,096.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,409.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	522,474.00	5,527.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,340.09	4,684.70
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	221.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,035.00	14,341.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,597.00	546.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,793.60	0.00			
			TOTAL ANCILLARY	835,257.66	76,294.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	835,257.66	76,294.90

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

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	31,975.43	ADJUSTMENTS	0.00
COVERED CHARGES	23,011.23	CONTRACTUAL ALLOW	13,002.43
NON-COVERD CHARGES	8,964.20	TOTAL MEDICAID LIAB	10,008.80
		LESS: COB	10,002.80
		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

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	371.60	83.20	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	181.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	892.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	6,592.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,616.00	190.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,412.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	545.63	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	993.00	2,099.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	23,011.23	8,964.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	23,011.23	8,964.20

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE 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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	651,584.68	ADJUSTMENTS	0.00
COVERED CHARGES	630,529.31	CONTRACTUAL ALLOW	575,936.85
NON-COVERD CHARGES	21,055.37	TOTAL MEDICAID LIAB	54,592.46
		LESS: COB	0.00
		LESS: COPAYMENT	177.00
		REIMBURSEMENT	54,415.46
		TOTAL NUMBER OF CLAIMS	9

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,024.80	249.60	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	20,714.04	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	401.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,577.00	180.00
EKG/ECG	0.00	886.00	MRI SERVICES	0.00	0.00
IV THERAPY	26,767.00	508.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	47,210.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	114.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,704.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,998.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	465,733.83	11,344.77
RADIOLOGY THERAPEUTIC	20,268.00	4,587.00	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	371.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	8,979.84	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	2,967.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,666.80	333.00			
			TOTAL ANCILLARY	630,529.31	21,055.37
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	630,529.31	21,055.37

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

Run Date: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	64,832.64	ADJUSTMENTS	0.00
COVERED CHARGES	64,832.64	CONTRACTUAL ALLOW	28,947.91
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	35,884.73
		LESS: COB	35,878.73
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT NEWNAN HOSPITAL INC
 745 POPLAR ROAD
 NEWNAN,GA 30265-1618

PROVIDER NUMBER
 000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	176.80	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	1,844.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	62,811.84	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	64,832.64	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	64,832.64	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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	88,393,302.54	ADJUSTMENTS	4,309,214.74
COVERED CHARGES	84,188,735.93	CONTRACTUAL ALLOW	56,153,300.99
NON-COVERD CHARGES	4,204,566.61	TOTAL MEDICAID LIAB	28,035,434.94
		LESS: COB	279,943.99
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	27,755,490.95

TOTAL NUMBER OF ADMISSIONS 2,211

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	11,200		5	13,978,020.00		1,993,829.01
ROUTINE NURSERY	1,150		2	1,446,125.00		22,074.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		1,425.00
TOTAL ROUTINE	12,350		7	15,424,145.00		2,017,328.01
SPECIAL CARE SERVICES						
CCU	212		0	1,035,450.00		0.00
ICU	1,583		0	7,722,975.00		14,625.00
NICU	495		0	1,410,817.00		223,295.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,290		0	10,169,242.00		237,920.00
TOTAL ACCOMODATIONS	14,640		7	25,593,387.00		2,255,248.01

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,396,581.10	124,290.56	OTHER LAB	484,089.00	702.00
MED/SURG SUPPLY	3,740,842.30	49,857.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,987,828.00	118,873.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,069,154.30	7,715.00	OTHER THERAPEUTIC SVC	0.00	256,436.00
CT SCAN	3,140,257.00	10,240.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,024,116.56	16,195.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	367,624.00	584.00	MRI SERVICES	1,704,213.00	0.00
IV THERAPY	2,383.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,716,584.22	19,857.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,236,834.00	7,273.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,162,406.02	62,435.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,851,429.00	3,971.00	AMBULANCE	0.00	0.00
GI SERVICES	394,988.00	6,919.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,056,058.00	4,916.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	698,695.00	7,477.00	DRUG-SPECIFIC/HOME IV	0.00	156,481.90
LABORATORY PATHOLOGIC	599,136.00	710.00	INJECTABLE DRUGS	6,997,235.24	39,863.14
RADIOLOGY THERAPEUTIC	47,458.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	381,382.85	3,803.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	214,568.71	1,547.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,303,055.00	140,347.00	PATIENT CONVENIENCE	0.00	12.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	315.00	3,004.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,914,174.63	703.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	390,248.00
OTHER IMAGING SERVICE	355,480.00	349,971.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,716,522.00	26,342.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	171,421.00	133,658.00			
AUDIOLOGY	12,641.00	0.00			
CARDIOLOGY	2,504,822.00	1,229.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	308,264.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	34,791.00	3,659.00			
			TOTAL ANCILLARY	58,595,348.93	1,949,318.60
			TOTAL ACCOMODATIONS	25,593,387.00	2,255,248.01
			TOTAL CHARGES	84,188,735.93	4,204,566.61

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015311000242	10/30/15 - 11/01/15	11/16/15	0.00	12,440.00	0.00	0.00	0.00
615	2315320000015	09/17/15 - 09/20/15	12/14/15	0.00	12,440.00	0.00	3,721.46	0.00
615	2015339022337	11/20/15 - 11/24/15	12/14/15	0.00	12,440.00	0.00	0.00	0.00
615	2015348028958	11/15/15 - 12/02/15	12/21/15	0.00	3,181.00	0.00	0.00	0.00
615	2015350087608	11/28/15 - 12/01/15	12/21/15	0.00	12,440.00	0.00	0.00	0.00
615	5215362023340	09/11/15 - 09/21/15	02/22/16	0.00	12,440.00	0.00	0.00	0.00
615	5215363001053	09/05/15 - 09/13/15	02/22/16	0.00	3,181.00	0.00	0.00	0.00
615	5215363001055	09/30/15 - 10/05/15	02/22/16	0.00	12,440.00	0.00	0.00	0.00
615	5215363004701	10/11/15 - 10/17/15	02/22/16	0.00	18,660.00	0.00	0.00	0.00
615	2016007092969	09/08/15 - 09/18/15	01/11/16	0.00	3,181.00	0.00	0.00	0.00
615	2016021086329	09/20/15 - 10/03/15	01/25/16	0.00	12,440.00	0.00	0.00	0.00
614	2016027094261	09/28/15 - 11/20/15	02/01/16	0.00	10,017.00	0.00	0.00	0.00
615	2016031018686	01/13/16 - 01/22/16	02/08/16	0.00	12,440.00	0.00	0.00	0.00
615	2016031018699	12/07/15 - 12/16/15	02/08/16	0.00	6,220.00	0.00	0.00	0.00
615	2016043078032	10/22/15 - 10/31/15	02/22/16	0.00	3,181.00	0.00	0.00	0.00
615	2316046000016	12/13/15 - 12/20/15	03/28/16	0.00	6,220.00	0.00	5,647.22	0.00
615	2016061053414	02/12/16 - 02/17/16	03/07/16	0.00	3,181.00	0.00	0.00	0.00
615	2016064077793	02/23/16 - 02/24/16	03/14/16	0.00	6,220.00	0.00	0.00	0.00
615	9816070001788	10/16/15 - 10/20/15	03/14/16	0.00	12,440.00	0.00	0.00	0.00
615	2016077080976	03/06/16 - 03/12/16	03/21/16	0.00	3,181.00	0.00	0.00	0.00
615	2016104073449	03/25/16 - 04/06/16	04/18/16	0.00	12,440.00	0.00	0.00	0.00
615	2016106079288	12/11/15 - 04/08/16	04/25/16	0.00	3,181.00	0.00	0.00	0.00
615	5216112000295	12/03/15 - 12/18/15	04/25/16	0.00	6,362.00	0.00	0.00	0.00
615	2216146010539	02/11/16 - 03/04/16	05/30/16	0.00	3,181.00	0.00	0.00	0.00
615	2016147001053	05/18/16 - 05/20/16	05/30/16	0.00	12,440.00	0.00	0.00	0.00
615	2016168077124	05/24/16 - 05/29/16	06/20/16	0.00	18,660.00	0.00	0.00	0.00
615	2016175078458	06/05/16 - 06/07/16	07/04/16	0.00	12,440.00	0.00	0.00	0.00
615	2016177026600	06/14/16 - 06/20/16	07/04/16	0.00	9,401.00	0.00	0.00	0.00
614	2316200000052	05/16/16 - 05/24/16	08/22/16	0.00	3,067.00	0.00	1,103.32	0.00
614	5216202000225	01/12/16 - 03/11/16	07/25/16	0.00	13,910.00	0.00	0.00	0.00
615	2016210072529	07/14/16 - 07/23/16	08/01/16	0.00	12,440.00	0.00	0.00	0.00
615	2016232065644	07/26/16 - 08/14/16	08/29/16	0.00	3,181.00	0.00	0.00	0.00
615	2016243056979	07/17/16 - 08/12/16	09/05/16	0.00	12,440.00	0.00	0.00	0.00
614	2316252000188	10/16/15 - 11/05/15	10/10/16	0.00	2,605.00	0.00	5,461.18	0.00
615	2016259081227	06/15/16 - 06/21/16	09/19/16	0.00	3,181.00	0.00	0.00	0.00
615	2016265065891	07/22/16 - 08/08/16	09/26/16	0.00	12,440.00	0.00	0.00	0.00
615	2216267017612	03/15/16 - 03/23/16	09/26/16	0.00	6,220.00	0.00	0.00	0.00
615	2316294000160	07/13/16 - 07/21/16	11/21/16	0.00	12,440.00	0.00	5,399.93	0.00
614	2316300000144	01/10/16 - 01/12/16	12/05/16	0.00	3,149.00	0.00	1,489.77	0.00
615	2016310026730	07/23/16 - 08/04/16	11/14/16	0.00	6,362.00	0.00	0.00	0.00
615	9816345000028	06/14/16 - 07/20/16	12/19/16	0.00	6,220.00	0.00	0.00	0.00
615	2016349066961	03/04/16 - 03/07/16	12/19/16	0.00	12,440.00	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

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SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL MIDTOWN		PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00			
550 PEACHTREE ST NE		000000503A	SERVICE DATES	09/01/15	THROUGH	08/31/16			
ATLANTA,GA 30308-2247			ADMISSION DATES	00/00/00	THROUGH	00/00/00			
615	2017059063811	08/23/16 - 09/01/16	03/06/17	0.00	12,440.00	0.00	0.00	0.00	0.00
614	2317066000280	07/20/16 - 09/13/16	03/20/17	0.00	6,960.00	0.00	0.00	0.00	0.00
614	2017090074088	08/27/16 - 09/06/16	04/10/17	0.00	4,265.00	0.00	0.00	0.00	0.00
TOTAL				0.00	390,248.00	0.00	22,822.88	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

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,207,684.43	ADJUSTMENTS	0.00
COVERED CHARGES	2,140,874.43	CONTRACTUAL ALLOW	1,083,880.81
NON-COVERD CHARGES	66,810.00	TOTAL MEDICAID LIAB	1,056,993.62
		LESS: COB	1,056,993.62
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 49

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	245		0	302,725.00		46,400.00
ROUTINE NURSERY	42		0	59,655.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	287		0	362,380.00		46,400.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	34		0	165,750.00		0.00
NICU	83		0	261,035.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	117		0	426,785.00		0.00
TOTAL ACCOMODATIONS	404		0	789,165.00		46,400.00

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	97,186.27	0.00	OTHER LAB	8,988.00	0.00
MED/SURG SUPPLY	80,103.55	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	225,037.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,980.00	0.00	OTHER THERAPEUTIC SVC	0.00	9,620.00
CT SCAN	28,807.00	640.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	17,710.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,380.00	0.00	MRI SERVICES	16,087.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	43,759.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	250,801.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	119,168.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	36,342.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,634.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	17,775.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,655.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	8,136.00	0.00	INJECTABLE DRUGS	175,196.59	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,952.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,937.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	10,466.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	20,657.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	9,401.00
OTHER IMAGING SERVICE	11,431.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	52,690.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,227.00	749.00			
AUDIOLOGY	139.00	0.00			
CARDIOLOGY	75,424.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,855.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	186.00	0.00			
			TOTAL ANCILLARY	1,351,709.43	20,410.00
			TOTAL ACCOMODATIONS	789,165.00	46,400.00
			TOTAL CHARGES	2,140,874.43	66,810.00

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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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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5215363006665	09/08/15 - 09/20/15	02/22/16	0.00	9,401.00	0.00	15,129.51	0.00
TOTAL				0.00	9,401.00	0.00	15,129.51	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 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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	34,644,874.63	ADJUSTMENTS	399,176.52
COVERED CHARGES	25,084,067.47	CONTRACTUAL ALLOW	19,084,014.59
NON-COVERD CHARGES	9,560,807.16	TOTAL MEDICAID LIAB	6,000,052.88
		LESS: COB	24,502.87
		LESS: COPAYMENT	19,498.99
		REIMBURSEMENT	5,956,051.02
		ALL OTHER	4,084,130.53
		FEE SCHEDULE-LAB	534,714.85
		INJECTABLE DRUGS	1,337,205.64
		TOTAL NUMBER OF CLAIMS	11,071

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	209,107.96	692,668.57	OTHER LAB	339,613.00	1,404.00
MED/SURG SUPPLY	647,932.02	4,097.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	113.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	915,448.00	109,012.00	OTHER THERAPEUTIC SVC	0.00	120,801.00
CT SCAN	1,790,970.00	1,656,287.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,945.00	14,058.03	FEE SCHEDULE LAB	4,923,082.75	320,221.00
EKG/ECG	244,740.00	7,154.00	MRI SERVICES	1,254,517.00	1,082,960.00
IV THERAPY	1,164,848.00	29,695.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,241,902.50	581,889.72	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	57,489.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	95,330.00	29,472.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	522,389.00	2,261.00	AMBULANCE	0.00	0.00
GI SERVICES	129,611.00	53,885.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,692,591.00	40,743.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	538,235.00	5,700.00	DRUG-SPECIFIC/HOME IV	0.00	112.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,337,559.08	1,956,864.01
RADIOLOGY THERAPEUTIC	280,055.00	12,484.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	7,047.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	657.00	13,141.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	305,278.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	119,495.00	7,212.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	74,069.20	549,049.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	53,111.00
OTHER IMAGING SERVICE	901,365.00	1,020,169.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	833,015.20	76,460.80			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	407,825.00	477,190.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	589,010.00	316,938.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,254.00	844.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	762,011.76	12,486.00			
			TOTAL ANCILLARY	25,084,067.47	9,560,807.16
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,084,067.47	9,560,807.16

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 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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015278032730	09/29/15 - 09/29/15	10/12/15	0.00	3,067.00	0.00	0.00	0.00
615	2016067028304	02/29/16 - 02/29/16	03/14/16	0.00	6,220.00	0.00	0.00	0.00
615	2016078080364	03/07/16 - 03/07/16	03/28/16	0.00	3,181.00	0.00	0.00	0.00
615	2016174064557	06/15/16 - 06/15/16	06/27/16	0.00	3,181.00	0.00	0.00	0.00
615	2016174064557	06/15/16 - 06/15/16	06/27/16	0.00	6,220.00	0.00	0.00	0.00
615	2016195069632	07/05/16 - 07/05/16	07/18/16	0.00	3,181.00	0.00	0.00	0.00
615	2016195069632	07/05/16 - 07/05/16	07/18/16	0.00	3,181.00	0.00	0.00	0.00
615	2016200024034	07/09/16 - 07/09/16	07/25/16	0.00	6,220.00	0.00	0.00	0.00
615	2016200024034	07/09/16 - 07/09/16	07/25/16	0.00	6,220.00	0.00	0.00	0.00
615	2216203012182	06/14/16 - 06/14/16	07/25/16	0.00	6,220.00	0.00	0.00	0.00
615	2216203012182	06/14/16 - 06/14/16	07/25/16	0.00	6,220.00	0.00	0.00	0.00
TOTAL				0.00	53,111.00	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

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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	803,976.38	ADJUSTMENTS	0.00
COVERED CHARGES	424,697.04	CONTRACTUAL ALLOW	113,982.81
NON-COVERD CHARGES	379,279.34	TOTAL MEDICAID LIAB	310,714.23
		LESS: COB	310,378.97
		LESS: COPAYMENT	335.26
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 191

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

EMORY UNIVERSITY HOSPITAL MIDTOWN
 550 PEACHTREE ST NE
 ATLANTA,GA 30308-2247

PROVIDER NUMBER
 000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,927.99	11,371.59	OTHER LAB	9,642.00	0.00
MED/SURG SUPPLY	16,868.55	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,536.00	0.00	OTHER THERAPEUTIC SVC	0.00	2,984.00
CT SCAN	6,151.00	36,303.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	692.00	FEE SCHEDULE LAB	91,592.00	6,405.00
EKG/ECG	3,066.00	146.00	MRI SERVICES	6,804.00	81,292.00
IV THERAPY	19,311.00	845.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	47,534.00	42,796.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,495.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	504.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	22,135.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,787.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	46,353.00	523.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	24,819.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,200.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	53,343.50	149,233.75
RADIOLOGY THERAPEUTIC	8,276.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	835.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,314.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	980.00	510.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	1,118.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	17,101.00
OTHER IMAGING SERVICE	5,093.00	4,012.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	18,795.00	480.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,579.00	5,928.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,829.00	4,916.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,063.00	7,487.00			
			TOTAL ANCILLARY	424,697.04	379,279.34
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	424,697.04	379,279.34

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 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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016214033947	04/22/16 - 04/22/16	08/08/16	0.00	3,181.00	0.00	0.00	0.00
614	2016235030075	03/04/16 - 03/04/16	08/29/16	0.00	6,960.00	0.00	1,318.76	0.00
614	2016235030075	03/04/16 - 03/04/16	08/29/16	0.00	6,960.00	0.00	1,318.76	0.00
TOTAL				0.00	17,101.00	0.00	2,637.52	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

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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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	415,937.19	ADJUSTMENTS	158.82
COVERED CHARGES	375,152.20	CONTRACTUAL ALLOW	349,643.56
NON-COVERD CHARGES	40,784.99	TOTAL MEDICAID LIAB	25,508.64
		LESS: COB	0.00
		LESS: COPAYMENT	1,197.76
		REIMBURSEMENT	24,310.88
		TOTAL NUMBER OF CLAIMS	456

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	264.62	3,875.42	OTHER LAB	5,187.00	0.00
MED/SURG SUPPLY	3,515.76	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,039.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,728.00	26,241.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	77,402.00	1,433.00
EKG/ECG	3,650.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,402.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,257.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,660.00	129.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,641.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	216,250.00	732.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,090.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,799.82	3,745.57
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	398.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	8.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,686.00	4,621.00			
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	1,182.00	0.00			
			TOTAL ANCILLARY	375,152.20	40,784.99
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	375,152.20	40,784.99

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

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

Run Date: 08/24/2017
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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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,810.39	ADJUSTMENTS	0.00
COVERED CHARGES	5,272.39	CONTRACTUAL ALLOW	3,780.08
NON-COVERD CHARGES	538.00	TOTAL MEDICAID LIAB	1,492.31
		LESS: COB	1,489.31
		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: 08/24/2017
 Run Time: 02:56:45
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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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1.79	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	110.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	901.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,231.00	264.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,025.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3.60	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
LITHOTRIPTY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	274.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	5,272.39	538.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,272.39	538.00

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

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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,638,318.69	ADJUSTMENTS	84,917.22
COVERED CHARGES	2,382,374.30	CONTRACTUAL ALLOW	1,682,021.09
NON-COVERD CHARGES	255,944.39	TOTAL MEDICAID LIAB	700,353.21
		LESS: COB	0.00
		LESS: COPAYMENT	856.07
		REIMBURSEMENT	699,497.14
		TOTAL NUMBER OF CLAIMS	115

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

EMORY UNIVERSITY HOSPITAL MIDTOWN	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
550 PEACHTREE ST NE	000000503A	SERVICE DATES	09/01/15	THROUGH	08/31/16
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	21,939.48	1,818.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	35,950.23	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,907.00	57,673.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,199.00	1,360.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	582.00	FEE SCHEDULE LAB	150,460.00	5,811.00
EKG/ECG	584.00	0.00	MRI SERVICES	27,216.00	0.00
IV THERAPY	244,564.00	1,116.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	342,522.00	27,570.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	613.00	129.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	47,766.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	727.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	22,306.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,210,440.59	49,249.39
RADIOLOGY THERAPEUTIC	44,245.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,739.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	84,668.00	92,980.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	962.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	43,338.00	4,739.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	8,444.00	6,902.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	66,798.00	4,190.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,725.00	86.00			
			TOTAL ANCILLARY	2,382,374.30	255,944.39
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,382,374.30	255,944.39

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: 08/24/2017
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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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	31,903.40	ADJUSTMENTS	0.00
COVERED CHARGES	31,868.40	CONTRACTUAL ALLOW	8,500.09
NON-COVERD CHARGES	35.00	TOTAL MEDICAID LIAB	23,368.31
		LESS: COB	23,362.31
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	35.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	85.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	29,207.40	0.00
RADIOLOGY THERAPEUTIC	2,576.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	31,868.40	35.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	31,868.40	35.00

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,561,137.12	ADJUSTMENTS	610,470.90
COVERED CHARGES	6,394,973.91	CONTRACTUAL ALLOW	3,643,360.51
NON-COVERD CHARGES	166,163.21	TOTAL MEDICAID LIAB	2,751,613.40
		LESS: COB	35,132.69
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,716,480.71

TOTAL NUMBER OF ADMISSIONS 332

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,039		0	726,050.00		23,094.00
ROUTINE NURSERY	36		0	25,200.00		10,740.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		16.00
TOTAL ROUTINE	1,075		0	751,250.00		33,850.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	448		0	669,760.00		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	448		0	669,760.00		0.00
TOTAL ACCOMODATIONS	1,523		0	1,421,010.00		33,850.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	480,960.58	1,345.21	OTHER LAB	22,799.00	0.00
MED/SURG SUPPLY	414,169.91	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,117,771.20	0.00	EDUCATION & TRAINING	26,609.00	0.00
RADIOLOGY-DIAGNOSTIC	115,221.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	490,809.00	2,871.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	55,054.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	52,682.00	0.00	MRI SERVICES	53,828.00	0.00
IV THERAPY	92,471.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	371,684.97	1,741.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	32,923.31	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	388,480.74	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	36,675.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	213,816.67	0.00	SPECIAL SERVICES	0.00	27,520.00
RECOVERY ROOM	41,915.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	9,670.68	0.00	INJECTABLE DRUGS	551,564.49	0.00
RADIOLOGY THERAPEUTIC	3,501.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	21,673.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,569.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	35,754.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,120.00	24,833.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	67,263.36	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	23,257.00
OTHER IMAGING SERVICE	40,637.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	83,224.00	48,922.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	8,188.00	1,824.00			
AUDIOLOGY	3,933.00	0.00			
CARDIOLOGY	109,587.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,545.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	21,864.00	0.00			
			TOTAL ANCILLARY	4,973,963.91	132,313.21
			TOTAL ACCOMODATIONS	1,421,010.00	33,850.00
			TOTAL CHARGES	6,394,973.91	166,163.21

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5215362015434	07/31/15 - 08/04/15	02/22/16	0.00	3,379.00	0.00	0.00	0.00
614	5215362020804	08/26/15 - 08/31/15	02/22/16	0.00	3,379.00	0.00	0.00	0.00
614	5215362020805	08/24/15 - 08/31/15	02/22/16	0.00	3,379.00	0.00	0.00	0.00
614	2016054050349	02/02/16 - 02/05/16	02/29/16	0.00	3,280.00	0.00	0.00	0.00
614	2216088003064	01/22/16 - 01/28/16	04/04/16	0.00	3,280.00	0.00	0.00	0.00
614	2016103046741	03/21/16 - 03/29/16	04/18/16	0.00	3,280.00	0.00	0.00	0.00
614	2216163000323	05/15/16 - 05/19/16	06/20/16	0.00	3,280.00	0.00	0.00	0.00
TOTAL				0.00	23,257.00	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

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,014.93	ADJUSTMENTS	0.00
COVERED CHARGES	1,734.93	CONTRACTUAL ALLOW	102.84
NON-COVERD CHARGES	280.00	TOTAL MEDICAID LIAB	1,632.09
		LESS: COB	1,632.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	0	0	0.00	0.00
ROUTINE NURSERY	1	0	700.00	280.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1	0	700.00	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	1	0	700.00	280.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	46.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	321.05	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	182.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	50.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	212.38	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	52.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	171.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,034.93	0.00
			TOTAL ACCOMODATIONS	700.00	280.00
			TOTAL CHARGES	1,734.93	280.00

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,107,744.96	ADJUSTMENTS	132,757.79
COVERED CHARGES	6,100,375.31	CONTRACTUAL ALLOW	4,828,563.89
NON-COVERD CHARGES	1,007,369.65	TOTAL MEDICAID LIAB	1,271,811.42
		LESS: COB	545.88
		LESS: COPAYMENT	4,760.45
		REIMBURSEMENT	1,266,505.09
		ALL OTHER	927,022.11
		FEE SCHEDULE-LAB	177,521.26
		INJECTABLE DRUGS	161,961.72
		TOTAL NUMBER OF CLAIMS	4,481

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	43,065.80	68,805.81	OTHER LAB	202,769.58	0.00
MED/SURG SUPPLY	195,650.49	15,434.27	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	396.00	EDUCATION & TRAINING	0.00	708.00
RADIOLOGY-DIAGNOSTIC	289,432.00	6,287.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	678,298.00	341,680.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	19,765.00	7,403.00	FEE SCHEDULE LAB	1,610,360.02	61,882.73
EKG/ECG	76,676.00	994.00	MRI SERVICES	184,612.00	15,349.00
IV THERAPY	153,057.00	20,075.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	499,041.42	99,689.43	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,277.00	1,638.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	39,043.98	13,856.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	68,700.00	645.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	662,888.83	45,092.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	57,116.00	588.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	580,829.29	141,427.55
RADIOLOGY THERAPEUTIC	35,838.00	799.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,098.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	367.00	1,895.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	183,272.50	15,200.48	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	17,252.90	10,928.38
LITHOTRIPSY	57,085.00	0.00	NO CC/INVALID REV CODE	0.00	13,439.00
OTHER IMAGING SERVICE	185,720.00	24,117.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	15,271.00	5,246.00			
ONCOLOGY	970.00	0.00			
NUCLEAR MEDICINE	87,177.00	76,236.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	61,209.00	11,432.00			
AMBULATORY SURGERY	3,245.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,072.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	82,313.50	3,533.00			
			TOTAL ANCILLARY	6,100,375.31	1,005,874.65
			TOTAL ACCOMODATIONS	0.00	1,495.00
			TOTAL CHARGES	6,100,375.31	1,007,369.65

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: 08/24/2017
Run Time: 02:37:23
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015266066874	08/12/15 - 08/12/15	09/28/15	0.00	3,379.00	0.00	0.00	0.00
614	2016053026381	01/28/16 - 01/28/16	02/29/16	0.00	3,280.00	0.00	0.00	0.00
614	2016130017902	04/11/16 - 04/11/16	05/16/16	0.00	3,280.00	0.00	0.00	0.00
614	2016146072764	04/27/16 - 04/27/16	05/30/16	0.00	3,280.00	0.00	0.00	0.00
9921	2216237002235	12/15/15 - 12/15/15	08/29/16	0.00	220.00	0.00	0.00	0.00
TOTAL				0.00	13,439.00	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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	96,502.74	ADJUSTMENTS	0.00
COVERED CHARGES	65,455.59	CONTRACTUAL ALLOW	18,071.32
NON-COVERD CHARGES	31,047.15	TOTAL MEDICAID LIAB	47,384.27
		LESS: COB	47,362.58
		LESS: COPAYMENT	21.69
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 66

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	408.87	975.85	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,798.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,786.00	413.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,188.00	11,618.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	34,336.03	817.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	6,758.00
IV THERAPY	1,832.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,184.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	660.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,130.35	401.00	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	1,411.94	93.30
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	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	6,560.00
OTHER IMAGING SERVICE	5,656.00	1,982.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,429.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	684.00	0.00			
			TOTAL ANCILLARY	65,455.59	31,047.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	65,455.59	31,047.15

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015350016051	10/26/15 - 10/26/15	12/21/15	0.00	3,280.00	0.00	0.00	0.00
614	2016145059149	04/25/16 - 04/25/16	05/30/16	0.00	3,280.00	0.00	0.00	0.00
TOTAL				0.00	6,560.00	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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	217,272.71	ADJUSTMENTS	329.64
COVERED CHARGES	194,892.00	CONTRACTUAL ALLOW	179,844.14
NON-COVERD CHARGES	22,380.71	TOTAL MEDICAID LIAB	15,047.86
		LESS: COB	0.00
		LESS: COPAYMENT	502.37
		REIMBURSEMENT	14,545.49
		TOTAL NUMBER OF CLAIMS	269

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

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

Run Date: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,414.73	885.56	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,933.63	78.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,783.00	391.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,471.00	15,944.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	75,142.00	1,488.00
EKG/ECG	2,982.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,829.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,092.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	217.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	330.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	79,685.72	2,248.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	588.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,090.92	643.18
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	702.97
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,333.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	194,892.00	22,380.71
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	194,892.00	22,380.71

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,288.58	ADJUSTMENTS	0.00
COVERED CHARGES	1,288.58	CONTRACTUAL ALLOW	471.66
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	816.92
		LESS: COB	816.92
		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

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3.03	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	14.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	645.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	626.55	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	1,288.58	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,288.58	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

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	377,798.13	ADJUSTMENTS	34,505.94
COVERED CHARGES	338,680.75	CONTRACTUAL ALLOW	252,363.40
NON-COVERD CHARGES	39,117.38	TOTAL MEDICAID LIAB	86,317.35
		LESS: COB	0.00
		LESS: COPAYMENT	57.00
		REIMBURSEMENT	86,260.35
		TOTAL NUMBER OF CLAIMS	15

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,517.71	1,567.31	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,597.76	510.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,832.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,813.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	15,040.00	192.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,931.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	3,092.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	20,358.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	266,936.28	32,021.07
RADIOLOGY THERAPEUTIC	8,490.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,165.00	136.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	170.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,429.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	338,680.75	39,117.38
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	338,680.75	39,117.38

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: 08/24/2017
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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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,372,388.30	ADJUSTMENTS	1,066,658.14
COVERED CHARGES	7,613,488.62	CONTRACTUAL ALLOW	6,129,679.51
NON-COVERD CHARGES	1,758,899.68	TOTAL MEDICAID LIAB	1,483,809.11
		LESS: COB	1,312.59
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,482,496.52

TOTAL NUMBER OF ADMISSIONS 36

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,332		0	1,115,070.08		1,563,359.84
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,332		0	1,115,070.08		1,563,359.84
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	407		0	902,169.94		41,622.66
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	407		0	902,169.94		41,622.66
TOTAL ACCOMODATIONS	1,739		0	2,017,240.02		1,604,982.50

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	771,620.14	11,224.70	OTHER LAB	9,701.11	0.00
MED/SURG SUPPLY	539,459.64	19,655.31	RECREATIONAL THERAPY	4,393.94	0.00
LABORATORY-GENERAL	549,929.05	18,951.19	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	91,517.79	1,127.74	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,211.45	944.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	118,718.13	235.96	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	13,565.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	79,352.86	1,386.92	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,931,437.62	70,895.84	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,866.70	0.00	AMBULANCE	0.00	0.00
GI SERVICES	10,395.38	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,474.70	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	4,417.51	0.00	INJECTABLE DRUGS	1,027,592.32	8,532.70
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	133,862.16	381.76	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	133,460.00	2,668.90	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	71,717.70	5,275.60	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	215.31	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,471.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	670.46
OTHER IMAGING SERVICE	3,998.05	718.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	28,870.00	11,247.60			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	21,145.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,236.97	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	21,619.07	0.00			
			TOTAL ANCILLARY	5,596,248.60	153,917.18
			TOTAL ACCOMODATIONS	2,017,240.02	1,604,982.50
			TOTAL CHARGES	7,613,488.62	1,758,899.68

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2216202001250	06/22/16 - 07/13/16	07/25/16	0.00	670.46	0.00	0.00	0.00
TOTAL				0.00	670.46	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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	839,854.00	ADJUSTMENTS	0.00
COVERED CHARGES	702,047.76	CONTRACTUAL ALLOW	466,891.62
NON-COVERD CHARGES	137,806.24	TOTAL MEDICAID LIAB	235,156.14
		LESS: COB	235,156.14
		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	112		0	96,432.00		125,873.44
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	112		0	96,432.00		125,873.44
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	40		0	92,494.80		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	40		0	92,494.80		0.00
TOTAL ACCOMODATIONS	152		0	188,926.80		125,873.44

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,401.70	0.00	OTHER LAB	932.93	0.00
MED/SURG SUPPLY	26,997.19	0.00	RECREATIONAL THERAPY	222.18	0.00
LABORATORY-GENERAL	39,361.63	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,596.28	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,698.41	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,500.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,918.22	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	352,504.14	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,397.68	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	11,932.80
LABORATORY PATHOLOGIC	592.03	0.00	INJECTABLE DRUGS	43,799.90	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,926.93	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,835.74	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	436.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	513,120.96	11,932.80
			TOTAL ACCOMODATIONS	188,926.80	125,873.44
			TOTAL CHARGES	702,047.76	137,806.24

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

Run Date: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
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

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 07/01/15 THROUGH 06/30/16
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: 08/24/2017
Run Time: 02:38:34
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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 07/01/15 THROUGH 06/30/16
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: 08/24/2017
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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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
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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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
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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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	53,216,038.10	ADJUSTMENTS	4,926,641.10
COVERED CHARGES	50,226,667.71	CONTRACTUAL ALLOW	32,449,530.07
NON-COVERD CHARGES	2,989,370.39	TOTAL MEDICAID LIAB	17,777,137.64
		LESS: COB	299,737.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	17,477,399.96

TOTAL NUMBER OF ADMISSIONS 2,655

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7,010		0	6,024,211.41		1,439,561.60
ROUTINE NURSERY	2,271		3	2,736,167.31		716,984.18
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	9,281		3	8,760,378.72		2,156,545.78
SPECIAL CARE SERVICES						
CCU	3		0	3,363.33		0.00
ICU	1,765		0	4,013,696.94		12,140.85
NICU	46		0	142,066.40		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		3	0.00		2,872.71
REHAB	0		362	0.00		402,985.64
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,814		365	4,159,126.67		417,999.20
TOTAL ACCOMODATIONS	11,095		368	12,919,505.39		2,574,544.98

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,338,717.86	288.10	OTHER LAB	642,308.75	0.00
MED/SURG SUPPLY	1,103,309.96	11,155.89	RECREATIONAL THERAPY	14,003.72	0.00
LABORATORY-GENERAL	6,397,767.43	11,787.43	EDUCATION & TRAINING	149.78	0.00
RADIOLOGY-DIAGNOSTIC	941,109.23	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,481,536.84	98,264.54	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	676,022.44	3,234.73	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	356,504.00	0.00	MRI SERVICES	304,052.00	2,766.00
IV THERAPY	738,635.55	1,315.15	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,381,344.97	1,541.38	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	830,583.13	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,807,282.69	14,734.84	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	551,044.67	0.00	AMBULANCE	0.00	0.00
GI SERVICES	140,337.17	1,178.12	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,371,560.63	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,419,352.42	700.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	270,184.20	0.00	INJECTABLE DRUGS	4,706,689.96	3,430.80
RADIOLOGY THERAPEUTIC	221,540.64	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	413,454.41	1,511.48	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	331,510.55	1,524.42	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	203,392.00	10,896.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	65,813.09	2,026.62	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	27,794.78	0.00	IMPL DEV CHARGE PATIENTS	731,128.91	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	327.12
OTHER IMAGING SERVICE	456,090.76	4,862.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	403,512.80	161,181.60			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	324,096.76	82,099.19			
AUDIOLOGY	113,258.28	0.00			
CARDIOLOGY	1,242,606.95	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	79,823.93	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	220,641.06	0.00			
			TOTAL ANCILLARY	37,307,162.32	414,825.41
			TOTAL ACCOMODATIONS	12,919,505.39	2,574,544.98
			TOTAL CHARGES	50,226,667.71	2,989,370.39

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5215362016015	09/07/15 - 09/11/15	02/22/16	0.00	109.04	0.00	0.00	0.00
948	2216113004044	11/26/15 - 11/27/15	04/25/16	0.00	109.04	0.00	0.00	0.00
948	2216127002772	04/22/16 - 04/26/16	05/09/16	0.00	109.04	0.00	0.00	0.00
TOTAL				0.00	327.12	0.00	0.00	0.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	570,703.22	ADJUSTMENTS	0.00
COVERED CHARGES	546,703.16	CONTRACTUAL ALLOW	265,080.26
NON-COVERD CHARGES	24,000.06	TOTAL MEDICAID LIAB	281,622.90
		LESS: COB	281,622.90
		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	89		0	76,629.00		8,594.73
ROUTINE NURSERY	33		0	48,414.50		13,243.01
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	122		0	125,043.50		21,837.74
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	8		0	19,425.36		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	8		0	19,425.36		0.00
TOTAL ACCOMODATIONS	130		0	144,468.86		21,837.74

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	107,302.60	0.00	OTHER LAB	3,627.25	0.00
MED/SURG SUPPLY	8,792.43	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	52,388.06	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,476.12	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,982.17	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	11,760.99	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	900.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	12,384.67	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	21,772.70	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	11,452.65	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	57,093.18	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,519.56	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,591.95	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,451.38	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	985.98	0.00	INJECTABLE DRUGS	58,895.96	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	810.14	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,694.28	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	358.85	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,009.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,591.28	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,822.00	2,162.32			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	835.32	0.00			
CARDIOLOGY	3,844.04	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	3,891.74	0.00			
			TOTAL ANCILLARY	402,234.30	2,162.32
			TOTAL ACCOMODATIONS	144,468.86	21,837.74
			TOTAL CHARGES	546,703.16	24,000.06

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: 08/24/2017
Run Time: 02:39:18
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,981,635.62	ADJUSTMENTS	595,571.23
COVERED CHARGES	20,347,190.54	CONTRACTUAL ALLOW	16,289,483.47
NON-COVERD CHARGES	2,634,445.08	TOTAL MEDICAID LIAB	4,057,707.07
		LESS: COB	7,971.41
		LESS: COPAYMENT	7,586.53
		REIMBURSEMENT	4,042,149.13
		ALL OTHER	3,611,052.61
		FEE SCHEDULE-LAB	276,847.80
		INJECTABLE DRUGS	154,248.72

TOTAL NUMBER OF CLAIMS 7,509

SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

DEKALB MEDICAL CENTER
 2701 N DECATUR RD
 DECATUR,GA 30033-5918

PROVIDER NUMBER
 000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	381,625.64	4,606.70	OTHER LAB	457,468.56	1,865.86
MED/SURG SUPPLY	273,752.82	84,149.18	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	23,370.54	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,083,950.80	14,807.61	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,483,559.83	270,896.61	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	56,532.41	30,195.14	FEE SCHEDULE LAB	3,259,039.91	355,625.02
EKG/ECG	423,575.95	1,500.00	MRI SERVICES	279,634.00	39,720.75
IV THERAPY	1,411,618.10	7,202.51	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,393,461.41	419,927.44	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,506.45	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	256,204.09	70,892.21	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	375,968.21	0.00	AMBULANCE	0.00	0.00
GI SERVICES	81,520.83	13,436.86	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,213,115.20	1,312.57	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	656,420.68	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,084.80
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	780,888.36	416,346.84
RADIOLOGY THERAPEUTIC	192,835.23	195,752.35	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,295.00	11,484.97	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	7,074.96	9,932.96	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	11,804.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	47,905.38	7,502.73	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	55,610.90	246,859.82
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,016,868.38	130,693.90			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	33,972.00	22,704.36			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	166,145.19	137,853.72			
AUDIOLOGY	6,903.43	0.00			
CARDIOLOGY	296,712.05	91,573.62			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	42,056.98	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	605,967.79	11,342.01			
			TOTAL ANCILLARY	20,347,190.54	2,634,445.08
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	20,347,190.54	2,634,445.08

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	344,861.71	ADJUSTMENTS	0.00
COVERED CHARGES	262,974.10	CONTRACTUAL ALLOW	122,426.89
NON-COVERD CHARGES	81,887.61	TOTAL MEDICAID LIAB	140,547.21
		LESS: COB	140,475.21
		LESS: COPAYMENT	72.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 108

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,327.40	3.50	OTHER LAB	6,529.05	0.00
MED/SURG SUPPLY	3,598.00	124.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,164.93	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,234.71	8,250.17	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	387.20	4,817.79	FEE SCHEDULE LAB	55,421.64	4,153.88
EKG/ECG	3,900.00	0.00	MRI SERVICES	6,258.00	2,377.00
IV THERAPY	10,288.94	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	19,228.36	30,059.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,442.57	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,820.46	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,674.10	CAST ROOM	0.00	0.00
EMERGENCY ROOM	70,381.42	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,529.94	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,690.60	7,072.20
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.02	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	969.66	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	537.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,671.68	17,072.93			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,308.00	2,162.32			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,384.41	2,878.70			
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	2,473.94	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,426.19	0.00			
			TOTAL ANCILLARY	262,974.10	81,887.61
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	262,974.10	81,887.61

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: 08/24/2017
Run Time: 02:40:29
Page: 10

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,062,807.63	ADJUSTMENTS	538.30
COVERED CHARGES	998,372.98	CONTRACTUAL ALLOW	964,753.05
NON-COVERD CHARGES	64,434.65	TOTAL MEDICAID LIAB	33,619.93
		LESS: COB	0.00
		LESS: COPAYMENT	1,146.90
		REIMBURSEMENT	32,473.03
		TOTAL NUMBER OF CLAIMS	601

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,211.40	75.00	OTHER LAB	8,313.55	0.00
MED/SURG SUPPLY	2,114.31	1,060.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,301.72	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	44,137.98	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	43,884.21	10,870.39	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	206,790.88	19,693.42
EKG/ECG	12,300.00	0.00	MRI SERVICES	2,269.00	1,415.00
IV THERAPY	48,412.48	1,964.86	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,103.53	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,127.74	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,330.62	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	523,138.37	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,981.08	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,687.30	2,905.20
RADIOLOGY THERAPEUTIC	1,704.23	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	60,159.72	15,411.15			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,180.00	1,081.16			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	6,695.70			
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	6,526.58	1,961.05			
			TOTAL ANCILLARY	998,372.98	64,434.65
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	998,372.98	64,434.65

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: 08/24/2017
Run Time: 02:40:35
Page: 12

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,252.42	ADJUSTMENTS	0.00
COVERED CHARGES	21,225.99	CONTRACTUAL ALLOW	10,292.66
NON-COVERD CHARGES	4,026.43	TOTAL MEDICAID LIAB	10,933.33
		LESS: COB	10,924.26
		LESS: COPAYMENT	9.07
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	12

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	78.50	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	342.19	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,752.49	232.63
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	637.45	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	170.01	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,688.40	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	284.20	86.20
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	537.05	3,707.60			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	711.70	0.00			
			TOTAL ANCILLARY	21,225.99	4,026.43
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	21,225.99	4,026.43

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,996,532.46	ADJUSTMENTS	78,318.64
COVERED CHARGES	1,752,190.83	CONTRACTUAL ALLOW	1,444,404.61
NON-COVERD CHARGES	244,341.63	TOTAL MEDICAID LIAB	307,786.22
		LESS: COB	4,233.22
		LESS: COPAYMENT	354.00
		REIMBURSEMENT	303,199.00

TOTAL NUMBER OF CLAIMS 55

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,553.40	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	69,587.55	5,372.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	27,872.33	1,565.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,384.39	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	5,768.42	FEE SCHEDULE LAB	45,776.63	2,741.98
EKG/ECG	6,300.00	600.00	MRI SERVICES	0.00	0.00
IV THERAPY	58,967.03	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	338,943.11	56,069.88	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	25,986.22	4,817.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	77,667.64	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,314.11	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,399.02	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	75,158.01	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	422,956.80	32,585.00
RADIOLOGY THERAPEUTIC	62,101.13	3,967.15	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,123.43	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	591.56	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	995.53	215.31	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	333,598.28	112,080.20
LITHOTRIPSY	22,346.41	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,590.20	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	436.00	1,081.16			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	127,844.00	10,552.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,413.04	5,210.79			
			TOTAL ANCILLARY	1,752,190.83	244,341.63
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,752,190.83	244,341.63

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: 08/24/2017
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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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
 Run Time: 02:40:48
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,761,224.17	ADJUSTMENTS	1,013,069.27
COVERED CHARGES	11,322,088.89	CONTRACTUAL ALLOW	7,214,244.40
NON-COVERD CHARGES	439,135.28	TOTAL MEDICAID LIAB	4,107,844.49
		LESS: COB	45,714.73
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,062,129.76

TOTAL NUMBER OF ADMISSIONS 501

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,767		0	1,521,387.00		344,972.69
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,767		0	1,521,387.00		344,972.69
SPECIAL CARE SERVICES						
CCU	5		0	5,808.95		0.00
ICU	471		0	1,130,070.36		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	476		0	1,135,879.31		0.00
TOTAL ACCOMODATIONS	2,243		0	2,657,266.31		344,972.69

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	880,549.60	0.00	OTHER LAB	106,611.50	0.00
MED/SURG SUPPLY	220,161.79	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,717,092.32	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	250,627.55	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	530,170.87	2,960.09	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	104,449.81	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	109,200.00	0.00	MRI SERVICES	80,706.00	0.00
IV THERAPY	358,942.06	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	407,226.83	886.07	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,239,760.65	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	105,023.20	0.00	AMBULANCE	0.00	0.00
GI SERVICES	50,537.32	1,396.58	CAST ROOM	0.00	0.00
EMERGENCY ROOM	808,683.88	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	66,320.67	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	33,450.30	0.00	INJECTABLE DRUGS	831,048.14	0.00
RADIOLOGY THERAPEUTIC	3,766.23	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	33,385.21	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	36,545.96	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	94,432.00	1,177.89	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,746.38	724.02	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	66,709.08	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	109.04
OTHER IMAGING SERVICE	103,777.08	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	107,515.00	65,950.76			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	88,670.08	20,958.14			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	185,077.07	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	15,600.62	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	22,035.38	0.00			
			TOTAL ANCILLARY	8,664,822.58	94,162.59
			TOTAL ACCOMODATIONS	2,657,266.31	344,972.69
			TOTAL CHARGES	11,322,088.89	439,135.28

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016044003397	01/25/16 - 02/02/16	02/22/16	0.00	109.04	0.00	0.00	0.00
TOTAL				0.00	109.04	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: 08/24/2017
 Run Time: 02:40:57
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	45,794.75	ADJUSTMENTS	0.00
COVERED CHARGES	41,872.01	CONTRACTUAL ALLOW	4,081.81
NON-COVERD CHARGES	3,922.74	TOTAL MEDICAID LIAB	37,790.20
		LESS: COB	37,790.20
		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	14		0	12,054.00		1,760.42
ROUTINE NURSERY	0		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	12,054.00		1,760.42
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	14		0	12,054.00		1,760.42

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,411.90	0.00	OTHER LAB	932.93	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,457.78	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,258.91	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,523.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,609.93	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,230.16	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	4,521.40	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.	872.00	2,162.32			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	29,818.01	2,162.32
			TOTAL ACCOMODATIONS	12,054.00	1,760.42
			TOTAL CHARGES	41,872.01	3,922.74

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: 08/24/2017
Run Time: 02:40:59
Page: 6

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,065,831.69	ADJUSTMENTS	259,303.49
COVERED CHARGES	12,312,262.32	CONTRACTUAL ALLOW	9,952,401.57
NON-COVERD CHARGES	753,569.37	TOTAL MEDICAID LIAB	2,359,860.75
		LESS: COB	3,987.97
		LESS: COPAYMENT	3,973.67
		REIMBURSEMENT	2,351,899.11
		ALL OTHER	2,153,728.63
		FEE SCHEDULE-LAB	163,800.98
		INJECTABLE DRUGS	34,369.50

TOTAL NUMBER OF CLAIMS 5,305

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	195,734.30	3,889.20	OTHER LAB	127,812.64	2,677.10
MED/SURG SUPPLY	101,998.61	6,109.65	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	8,316.04	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	795,232.28	10,172.51	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,079,232.82	142,275.17	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	165,469.74	20,877.19	FEE SCHEDULE LAB	1,993,839.84	177,180.10
EKG/ECG	249,128.19	300.00	MRI SERVICES	182,323.00	18,978.90
IV THERAPY	930,824.98	4,673.97	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	412,786.32	48,179.71	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	85,162.67	9,195.09	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	120,129.44	0.00	AMBULANCE	0.00	0.00
GI SERVICES	9,262.18	6,696.40	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,261,965.30	1,550.33	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	113,071.81	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,385.80
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	254,563.40	48,855.60
RADIOLOGY THERAPEUTIC	166,412.39	4,483.74	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	21,151.40	10,853.33	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,747.30	5,171.19	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	12,343.78	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,294.87	5,310.98	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	42,895.72	10,368.18
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	561,361.27	77,263.56			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,104.00	3,243.48			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	80,174.57	56,185.25			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	63,588.80	36,229.40			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	22,390.28	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	263,604.20	20,803.72			
			TOTAL ANCILLARY	12,312,262.32	753,569.37
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,312,262.32	753,569.37

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	228,292.80	ADJUSTMENTS	0.00
COVERED CHARGES	174,890.50	CONTRACTUAL ALLOW	76,926.02
NON-COVERD CHARGES	53,402.30	TOTAL MEDICAID LIAB	97,964.48
		LESS: COB	97,934.48
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 75

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,464.00	145.30	OTHER LAB	4,044.96	0.00
MED/SURG SUPPLY	570.23	130.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,852.51	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,387.78	18,523.01	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	974.87	7,518.99	FEE SCHEDULE LAB	38,317.19	2,370.19
EKG/ECG	3,300.00	0.00	MRI SERVICES	2,766.00	0.00
IV THERAPY	14,544.60	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	390.85	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	785.18	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,119.94	CAST ROOM	0.00	0.00
EMERGENCY ROOM	70,327.70	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	5,253.60	1,369.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	494.19	6,840.37	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,912.33	10,318.95			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	436.00	1,081.16			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	2,984.89			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	891.88	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	1,176.63	0.00			
			TOTAL ANCILLARY	174,890.50	53,402.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	174,890.50	53,402.30

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,008,932.93	ADJUSTMENTS	491.43
COVERED CHARGES	986,768.28	CONTRACTUAL ALLOW	942,463.80
NON-COVERD CHARGES	22,164.65	TOTAL MEDICAID LIAB	44,304.48
		LESS: COB	0.00
		LESS: COPAYMENT	1,274.92
		REIMBURSEMENT	43,029.56
		TOTAL NUMBER OF CLAIMS	792

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,515.80	0.00	OTHER LAB	2,798.79	0.00
MED/SURG SUPPLY	1,785.00	130.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	650.86	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	46,677.17	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	37,491.93	1,327.39	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	160,296.62	8,513.09
EKG/ECG	7,500.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	58,038.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	603,516.05	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,485.60	2,539.70
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	215.31	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	50.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	43,035.30	8,788.30			
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	1,577.77	0.00			
			TOTAL ANCILLARY	986,768.28	22,164.65
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	986,768.28	22,164.65

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	300.90	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	342.19	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,731.93	921.50
EKG/ECG	600.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,535.23	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	11,591.27	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	153.80	79.80
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	2,771.50	3,030.25			
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	26,026.82	4,031.55
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	26,026.82	4,031.55

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	59,067.64	ADJUSTMENTS	0.00
COVERED CHARGES	58,999.98	CONTRACTUAL ALLOW	46,848.20
NON-COVERD CHARGES	67.66	TOTAL MEDICAID LIAB	12,151.78
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	12,145.78
		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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	90.10	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,733.06	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	590.51	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	262.49	67.66
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,201.04	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,661.08	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,266.01	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20.60	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	21,175.09	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	58,999.98	67.66
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	58,999.98	67.66

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: 08/24/2017
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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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
 Run Time: 02:42:10
 Page: 1

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

DOCTORS HOSPITAL OF AUGUSTA, LLC
 3651 WHEELER RD
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER 000000558A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	93,879,139.25	ADJUSTMENTS	6,865,113.68
COVERED CHARGES	91,463,571.03	CONTRACTUAL ALLOW	78,427,218.31
NON-COVERD CHARGES	2,415,568.22	TOTAL MEDICAID LIAB	13,036,352.72
		LESS: COB	72,496.49
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	12,963,856.23

TOTAL NUMBER OF ADMISSIONS 760

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,508		22	1,459,636.00		466,115.00
ROUTINE NURSERY	224		0	335,120.00		48,823.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,732		22	1,794,756.00		514,938.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,635		0	4,706,701.00		87,044.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	852		0	7,527,042.00		46,312.00
HOSPICE	0		0	0.00		0.00
REHAB	0		156	0.00		247,055.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,487		156	12,233,743.00		380,411.00
TOTAL ACCOMODATIONS	4,219		178	14,028,499.00		895,349.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

DOCTORS HOSPITAL OF AUGUSTA, LLC
 3651 WHEELER RD
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER
 000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,596,593.94	173,323.04	OTHER LAB	279,515.10	3,200.50
MED/SURG SUPPLY	10,548,784.35	115,210.31	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,689,260.25	108,654.72	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	958,241.08	4,466.58	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,576,930.24	292,421.54	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	417,421.17	3,648.19	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	289,768.02	0.00	MRI SERVICES	388,429.17	17,962.49
IV THERAPY	53,531.17	179.81	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,833,996.50	99,545.36	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	155,974.31	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,722,252.82	28,146.52	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	318,077.20	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	871,847.20	2,038.70	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,673,659.93	8,728.76	DRUG-SPECIFIC/HOME IV	0.00	3,831.80
LABORATORY PATHOLOGIC	312,176.82	1,824.26	INJECTABLE DRUGS	17,846,234.34	187,556.06
RADIOLOGY THERAPEUTIC	49,475.65	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	541,246.09	8,482.28	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	131,553.05	452.39	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	579,422.08	0.00	PATIENT CONVENIENCE	0.00	3,379.03
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	15,279.70	39,925.16	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	820,359.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	282,594.24	15,022.60			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,011,205.77	402,219.12			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	339,725.08	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	951,148.66	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	67,434.18	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	112,934.42	0.00			
			TOTAL ANCILLARY	77,435,072.03	1,520,219.22
			TOTAL ACCOMODATIONS	14,028,499.00	895,349.00
			TOTAL CHARGES	91,463,571.03	2,415,568.22

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

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

Run Date: 08/24/2017
 Run Time: 02:42:27
 Page: 3

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

DOCTORS HOSPITAL OF AUGUSTA, LLC
 3651 WHEELER RD
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER
 000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	225,810.82	ADJUSTMENTS	0.00
COVERED CHARGES	185,642.82	CONTRACTUAL ALLOW	114,388.19
NON-COVERD CHARGES	40,168.00	TOTAL MEDICAID LIAB	71,254.63
		LESS: COB	71,254.63
		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	17		0	16,847.00		39,667.00
ROUTINE NURSERY	3		0	2,973.00		501.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	20		0	19,820.00		40,168.00
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	20		0	19,820.00		40,168.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

DOCTORS HOSPITAL OF AUGUSTA, LLC
 3651 WHEELER RD
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER
 000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,724.99	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	24,478.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,375.90	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	85,257.90	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,629.24	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,028.14	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,004.18	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,448.54	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,672.20	0.00	INJECTABLE DRUGS	20,975.76	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	227.22	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	165,822.82	0.00
			TOTAL ACCOMODATIONS	19,820.00	40,168.00
			TOTAL CHARGES	185,642.82	40,168.00

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: 08/24/2017
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DOCTORS HOSPITAL OF AUGUSTA, LLC
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/15 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,251,245.77	ADJUSTMENTS	110,837.27
COVERED CHARGES	18,927,535.49	CONTRACTUAL ALLOW	17,229,393.81
NON-COVERD CHARGES	2,323,710.28	TOTAL MEDICAID LIAB	1,698,141.68
		LESS: COB	6,275.23
		LESS: COPAYMENT	5,289.15
		REIMBURSEMENT	1,686,577.30
		ALL OTHER	1,549,358.22
		FEE SCHEDULE-LAB	113,895.08
		INJECTABLE DRUGS	23,324.00

TOTAL NUMBER OF CLAIMS 5,013

DOCTORS HOSPITAL OF AUGUSTA, LLC
 3651 WHEELER RD
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER
 000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	267,604.76	315.26	OTHER LAB	88,862.60	0.00
MED/SURG SUPPLY	888,174.51	71,418.79	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	327.80	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	715,520.66	3,605.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,032,284.76	271,410.67	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	53,285.81	40,178.12	FEE SCHEDULE LAB	1,464,617.83	89,937.15
EKG/ECG	403,105.09	1,429.02	MRI SERVICES	191,787.41	36,579.37
IV THERAPY	785,504.97	6,623.32	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,518,606.08	773,287.42	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	206,990.69	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	112,142.05	34,142.37	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	287,343.70	68,861.30	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,755,903.18	8,109.35	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,270,359.28	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	207,016.97	84,875.63
RADIOLOGY THERAPEUTIC	625,821.52	261,062.54	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,121.33	15,502.22	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,077.62	940.22	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,532.59	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	256,450.64	11,791.25	TRAUMA RESPONSE	0.00	9,900.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	43,839.00	1,815.00
LITHOTRIPSY	24,110.54	0.00	NO CC/INVALID REV CODE	0.00	23,312.50
OTHER IMAGING SERVICE	395,010.16	65,185.91			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,219.91	1,662.31			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	594,459.40	197,227.56			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	242,515.94	211,098.87			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	15,172.68	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	465,626.40	30,577.99			
			TOTAL ANCILLARY	18,927,535.49	2,323,710.28
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,927,535.49	2,323,710.28

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

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DOCTORS HOSPITAL OF AUGUSTA, LLC
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/15 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015195019885	06/30/15 - 06/30/15	07/20/15	0.00	23,312.50	0.00	0.00	0.00
TOTAL				0.00	23,312.50	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

DOCTORS HOSPITAL OF AUGUSTA, LLC
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/15 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	755,521.01	ADJUSTMENTS	0.00
COVERED CHARGES	494,980.21	CONTRACTUAL ALLOW	299,920.13
NON-COVERD CHARGES	260,540.80	TOTAL MEDICAID LIAB	195,060.08
		LESS: COB	194,988.08
		LESS: COPAYMENT	72.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 121

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

DOCTORS HOSPITAL OF AUGUSTA, LLC
 3651 WHEELER RD
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER
 000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,020.60	0.00	OTHER LAB	3,519.20	0.00
MED/SURG SUPPLY	16,692.00	109.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,634.90	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,321.10	20,578.18	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	4,876.06	FEE SCHEDULE LAB	35,014.94	705.65
EKG/ECG	6,716.39	714.51	MRI SERVICES	0.00	6,416.05
IV THERAPY	13,951.72	216.14	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	169,398.09	71,070.02	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,684.82	4,286.33	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,634.44	1,016.54	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	4,650.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	83,426.25	2,332.85	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	49,875.69	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,901.17	45.22
RADIOLOGY THERAPEUTIC	15,759.21	95,410.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	411.92	4,725.53	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,372.49	227.22	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,438.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	21,161.98	9,507.41			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	11,716.26	28,702.06			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,604.83	3,911.65			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,060.49	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,663.72	1,039.88			
			TOTAL ANCILLARY	494,980.21	260,540.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	494,980.21	260,540.80

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: 08/24/2017
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DOCTORS HOSPITAL OF AUGUSTA, LLC
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/15 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	587,251.33	ADJUSTMENTS	55.94
COVERED CHARGES	578,228.57	CONTRACTUAL ALLOW	554,789.71
NON-COVERD CHARGES	9,022.76	TOTAL MEDICAID LIAB	23,438.86
		LESS: COB	0.00
		LESS: COPAYMENT	702.00
		REIMBURSEMENT	22,736.86
		TOTAL NUMBER OF CLAIMS	419

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL OF AUGUSTA, LLC
 3651 WHEELER RD
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER
 000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,873.95	0.00	OTHER LAB	711.42	0.00
MED/SURG SUPPLY	2,560.50	39.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	35,630.41	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	60,629.55	2,857.09	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	44,194.61	3,733.69
EKG/ECG	15,647.76	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	32,056.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,340.69	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,220.18	508.27	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	359,336.50	298.51	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,060.63	238.53
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	321.45	109.24	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,644.42	1,237.68			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	578,228.57	9,022.76
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	578,228.57	9,022.76

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: 08/24/2017
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DOCTORS HOSPITAL OF AUGUSTA, LLC
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER 000000558A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/15 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,245.81	ADJUSTMENTS	0.00
COVERED CHARGES	15,269.44	CONTRACTUAL ALLOW	7,699.44
NON-COVERD CHARGES	976.37	TOTAL MEDICAID LIAB	7,570.00
		LESS: COB	7,558.00
		LESS: COPAYMENT	12.00
		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

Run Date: 08/24/2017
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL OF AUGUSTA, LLC
 3651 WHEELER RD
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER
 000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 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	109.75	52.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	630.69	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	0.00	FEE SCHEDULE LAB	2,066.25	0.00
EKG/ECG	714.51	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	602.07	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	510.76	924.12	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,557.85	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	77.56	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	15,269.44	976.37
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,269.44	976.37

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 AUGUSTA, LLC
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/15 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	730,171.94	ADJUSTMENTS	0.00
COVERED CHARGES	721,235.12	CONTRACTUAL ALLOW	681,410.93
NON-COVERD CHARGES	8,936.82	TOTAL MEDICAID LIAB	39,824.19
		LESS: COB	0.00
		LESS: COPAYMENT	69.00
		REIMBURSEMENT	39,755.19

TOTAL NUMBER OF CLAIMS 7

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

DOCTORS HOSPITAL OF AUGUSTA, LLC
 3651 WHEELER RD
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER
 000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,443.06	0.00	OTHER LAB	1,919.15	0.00
MED/SURG SUPPLY	21,489.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,250.25	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	2,190.89	0.00
EKG/ECG	2,214.98	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	611.73	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	103,273.86	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	510.76	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	17,002.58	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,176.51	491.33
RADIOLOGY THERAPEUTIC	329,842.61	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	117.98	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	176,026.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	48,303.03	8,327.51			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,980.21	0.00			
			TOTAL ANCILLARY	721,235.12	8,936.82
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	721,235.12	8,936.82

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: 08/24/2017
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DOCTORS HOSPITAL OF AUGUSTA, LLC
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER
000000558A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/15	THROUGH	03/31/16
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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,606,794.32	ADJUSTMENTS	39,413.72
COVERED CHARGES	3,501,972.36	CONTRACTUAL ALLOW	2,129,517.52
NON-COVERD CHARGES	104,821.96	TOTAL MEDICAID LIAB	1,372,454.84
		LESS: COB	16,014.93
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,356,439.91

TOTAL NUMBER OF ADMISSIONS 199

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	850		0	637,500.00		67,650.00
ROUTINE NURSERY	26		0	11,310.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		4,500.00
TOTAL ROUTINE	876		0	648,810.00		72,150.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	231		0	337,260.00		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	231		0	337,260.00		0.00
TOTAL ACCOMODATIONS	1,107		0	986,070.00		72,150.00

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	378,220.91	0.00	OTHER LAB	7,249.52	0.00
MED/SURG SUPPLY	323,078.03	22.12	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	525,812.31	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	68,962.80	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	166,780.95	1,548.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	43,815.18	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	39,814.30	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	59,283.19	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	98,722.31	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,492.38	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	204,764.80	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	68,379.69	0.00	AMBULANCE	0.00	0.00
GI SERVICES	15,766.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	168,467.74	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,779.44	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,002.34	0.00	INJECTABLE DRUGS	159,287.58	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	676.42	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	74,335.31	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,476.44	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	69,809.87	31,101.59			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	1,136.43	0.00			
CARDIOLOGY	16,010.21	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,778.21	0.00			
			TOTAL ANCILLARY	2,515,902.36	32,671.96
			TOTAL ACCOMODATIONS	986,070.00	72,150.00
			TOTAL CHARGES	3,501,972.36	104,821.96

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

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

Run Date: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
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: 08/24/2017
Run Time: 02:43:38
Page: 4

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,649,863.85	ADJUSTMENTS	65,114.69
COVERED CHARGES	3,553,000.00	CONTRACTUAL ALLOW	2,867,768.98
NON-COVERD CHARGES	96,863.85	TOTAL MEDICAID LIAB	685,231.02
		LESS: COB	2,110.58
		LESS: COPAYMENT	2,455.99
		REIMBURSEMENT	680,664.45
		ALL OTHER	612,171.31
		FEE SCHEDULE-LAB	66,166.92
		INJECTABLE DRUGS	2,326.22
		TOTAL NUMBER OF CLAIMS	2,292

DODGE COUNTY HOSPITAL
 901 GRIFFIN AVE
 EASTMAN,GA 31023-6720

PROVIDER NUMBER
 000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63,021.89	13.70	OTHER LAB	151,056.03	0.00
MED/SURG SUPPLY	247,260.89	117.95	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	269.26	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	238,375.79	156.11	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	437,230.62	15,579.78	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	12,262.17	4,998.27	FEE SCHEDULE LAB	653,273.51	30,449.23
EKG/ECG	82,045.60	825.52	MRI SERVICES	107,539.79	0.00
IV THERAPY	166,328.41	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	190,001.46	14,473.96	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	82,237.93	507.47	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	18,382.83	2,205.78	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	130,265.14	1,118.99	AMBULANCE	0.00	0.00
GI SERVICES	28,621.71	1,450.33	CAST ROOM	0.00	0.00
EMERGENCY ROOM	694,375.38	1,209.52	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	16,776.49	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	32,363.90	8,091.62
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	86.17	1,562.11	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	21,570.82	1,083.72
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	37,272.91	4,610.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,384.45	4,621.28			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	31,316.16	1,596.63			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	34,473.35	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,453.65	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	64,022.95	1,922.12			
			TOTAL ANCILLARY	3,553,000.00	96,863.85
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,553,000.00	96,863.85

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: 08/24/2017
Run Time: 02:44:00
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,707.16	ADJUSTMENTS	0.00
COVERED CHARGES	19,578.08	CONTRACTUAL ALLOW	10,676.74
NON-COVERD CHARGES	3,129.08	TOTAL MEDICAID LIAB	8,901.34
		LESS: COB	8,892.34
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 15

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	172.23	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	392.83	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	99.25	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	526.35	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,922.11	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,211.39	107.72
EKG/ECG	605.84	0.00	MRI SERVICES	5,511.99	0.00
IV THERAPY	970.53	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,058.54	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	51.89	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,826.31	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,250.18	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	19,578.08	3,129.08
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	19,578.08	3,129.08

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

Run Date: 08/24/2017
Run Time: 02:44:01
Page: 8

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	194,064.74	ADJUSTMENTS	382.58
COVERED CHARGES	191,821.29	CONTRACTUAL ALLOW	176,773.43
NON-COVERD CHARGES	2,243.45	TOTAL MEDICAID LIAB	15,047.86
		LESS: COB	0.00
		LESS: COPAYMENT	629.50
		REIMBURSEMENT	14,418.36
		TOTAL NUMBER OF CLAIMS	269

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,218.97	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,403.45	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,177.49	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,683.93	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	26,518.36	2,140.43
EKG/ECG	3,332.12	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,001.12	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,450.33	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	327.81	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	900.41	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	130,670.51	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	1,539.89	103.02
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	457.48	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	139.42	0.00			
			TOTAL ANCILLARY	191,821.29	2,243.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	191,821.29	2,243.45

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

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,174.17	ADJUSTMENTS	0.00
COVERED CHARGES	4,427.63	CONTRACTUAL ALLOW	3,595.39
NON-COVERD CHARGES	4,746.54	TOTAL MEDICAID LIAB	832.24
		LESS: COB	826.24
		LESS: COPAYMENT	6.00
		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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	130.81	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	106.53	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	4,692.68	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,363.31	53.86
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	804.02	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,982.85	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	40.11	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,427.63	4,746.54
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,427.63	4,746.54

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

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/15	THROUGH	09/30/16
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

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/15	THROUGH	09/30/16
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

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 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,996,048.76	ADJUSTMENTS	75,602.20
COVERED CHARGES	1,926,619.01	CONTRACTUAL ALLOW	1,134,900.51
NON-COVERD CHARGES	69,429.75	TOTAL MEDICAID LIAB	791,718.50
		LESS: COB	19,653.59
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	772,064.91

TOTAL NUMBER OF ADMISSIONS 141

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	272		0	134,855.00		5,000.00
ROUTINE NURSERY	44		0	11,440.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	316		0	146,295.00		5,000.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	135		0	162,000.00		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	135		0	162,000.00		0.00
TOTAL ACCOMODATIONS	451		0	308,295.00		5,000.00

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

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

Run Date: 08/24/2017
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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 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	270,072.20	19,012.50	OTHER LAB	6,678.50	0.00
MED/SURG SUPPLY	156,339.81	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	374,326.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	39,195.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	144,836.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,730.25	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	37,992.00	0.00	MRI SERVICES	21,524.00	0.00
IV THERAPY	6,578.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	89,487.75	5,344.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	13,190.25	7,342.75	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	115,034.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,462.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	114,639.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,854.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,116.50	0.00	INJECTABLE DRUGS	113,224.75	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	730.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	383.50	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	6,063.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	20,499.50	2,619.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	11,302.50	152.25			
AUDIOLOGY	366.25	0.00			
CARDIOLOGY	32,105.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,235.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	738.50	29,575.00			
			TOTAL ANCILLARY	1,618,324.01	64,429.75
			TOTAL ACCOMODATIONS	308,295.00	5,000.00
			TOTAL CHARGES	1,926,619.01	69,429.75

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

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

Run Date: 08/24/2017
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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 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,091.47	ADJUSTMENTS	0.00
COVERED CHARGES	4,716.47	CONTRACTUAL ALLOW	508.37
NON-COVERD CHARGES	375.00	TOTAL MEDICAID LIAB	4,208.10
		LESS: COB	4,208.10
		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	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	2		0	950.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	2		0	950.00		0.00

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 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	582.00	110.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,267.47	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	591.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	928.75	265.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	70.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	326.75	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	3,766.47	375.00
			TOTAL ACCOMODATIONS	950.00	0.00
			TOTAL CHARGES	4,716.47	375.00

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: 08/24/2017
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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 08/01/15 THROUGH 07/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,296,660.06	ADJUSTMENTS	28,926.18
COVERED CHARGES	3,841,190.98	CONTRACTUAL ALLOW	2,747,478.06
NON-COVERD CHARGES	455,469.08	TOTAL MEDICAID LIAB	1,093,712.92
		LESS: COB	2,832.09
		LESS: COPAYMENT	1,434.00
		REIMBURSEMENT	1,089,446.83
		ALL OTHER	999,827.48
		FEE SCHEDULE-LAB	72,347.65
		INJECTABLE DRUGS	17,271.70

TOTAL NUMBER OF CLAIMS 2,203

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 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,697.75	103,206.50	OTHER LAB	29,083.25	0.00
MED/SURG SUPPLY	111,195.97	142.86	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	98.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	222,303.75	1,216.50	OTHER THERAPEUTIC SVC	0.00	3,343.75
CT SCAN	747,892.75	39,066.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,437.50	1,658.23	FEE SCHEDULE LAB	838,860.50	47,724.75
EKG/ECG	68,586.00	8,876.50	MRI SERVICES	74,276.75	22,642.00
IV THERAPY	134,488.75	7,182.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	159,284.01	25,087.74	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	25,647.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	29,270.00	22,366.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	26,440.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	718,830.00	6,185.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	38,926.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	140,844.00	61,379.25
RADIOLOGY THERAPEUTIC	20,258.75	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	192.50	192.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	365.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	9,941.25	2,835.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	854.25
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	106.00
OTHER IMAGING SERVICE	76,202.50	10,994.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	20,093.50	7,202.25			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	90,808.50	31,940.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	44,181.75	48,613.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	114,193.25	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	57,254.75	2,189.25			
			TOTAL ANCILLARY	3,841,190.98	455,469.08
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,841,190.98	455,469.08

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: 08/24/2017
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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 08/01/15 THROUGH 07/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5916244000996	07/30/16 - 07/30/16	09/05/16	0.00	106.00	0.00	0.00	0.00
TOTAL				0.00	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
SUMMARY TYPE IV

Run Date: 08/24/2017
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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 08/01/15 THROUGH 07/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,210.39	ADJUSTMENTS	0.00
COVERED CHARGES	16,851.11	CONTRACTUAL ALLOW	5,630.03
NON-COVERD CHARGES	12,359.28	TOTAL MEDICAID LIAB	11,221.08
		LESS: COB	11,216.22
		LESS: COPAYMENT	4.86
		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 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	404.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	308.11	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,156.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	5,347.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	168.25	0.03	FEE SCHEDULE LAB	6,293.00	378.00
EKG/ECG	309.50	0.00	MRI SERVICES	0.00	3,465.50
IV THERAPY	325.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	309.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,854.25	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	10.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,764.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,116.75	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	16,851.11	12,359.28
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,851.11	12,359.28

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

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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 08/01/15 THROUGH 07/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	433,387.79	ADJUSTMENTS	211.76
COVERED CHARGES	411,006.04	CONTRACTUAL ALLOW	385,049.88
NON-COVERD CHARGES	22,381.75	TOTAL MEDICAID LIAB	25,956.16
		LESS: COB	0.00
		LESS: COPAYMENT	1,002.20
		REIMBURSEMENT	24,953.96
		TOTAL NUMBER OF CLAIMS	464

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 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	719.50	9,153.00	OTHER LAB	3,121.00	0.00
MED/SURG SUPPLY	4,112.79	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	30,591.50	2,015.00	OTHER THERAPEUTIC SVC	0.00	91.75
CT SCAN	60,065.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	84,815.50	5,326.00
EKG/ECG	9,904.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,539.50	331.50	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	164.50	1,266.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	194,237.75	292.50	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	12,915.50	1,430.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,527.50	2,476.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	653.50	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	638.00	0.00			
			TOTAL ANCILLARY	411,006.04	22,381.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	411,006.04	22,381.75

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 08/01/15 THROUGH 07/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,755.75	ADJUSTMENTS	0.00
COVERED CHARGES	3,532.00	CONTRACTUAL ALLOW	2,990.12
NON-COVERD CHARGES	223.75	TOTAL MEDICAID LIAB	541.88
		LESS: COB	535.88
		LESS: COPAYMENT	6.00
		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

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 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	30.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	41.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	301.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,489.00	183.75
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,700.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	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	3,532.00	223.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,532.00	223.75

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

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 08/01/15 THROUGH 07/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	593,891.10	ADJUSTMENTS	0.00
COVERED CHARGES	572,998.85	CONTRACTUAL ALLOW	467,363.75
NON-COVERD CHARGES	20,892.25	TOTAL MEDICAID LIAB	105,635.10
		LESS: COB	0.00
		LESS: COPAYMENT	168.00
		REIMBURSEMENT	105,467.10

TOTAL NUMBER OF CLAIMS 19

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 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,816.00	5,689.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	27,678.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,472.50	1,117.50	OTHER THERAPEUTIC SVC	0.00	3,778.75
CT SCAN	2,063.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	25,770.75	2,029.00
EKG/ECG	928.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,434.00	273.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	35,351.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	329.00	105.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,044.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,013.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,486.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	387,770.75	3,802.00
RADIOLOGY THERAPEUTIC	48,254.50	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	4,193.50	3,181.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	297.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	619.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,392.00	0.00			
			TOTAL ANCILLARY	572,998.85	20,892.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	572,998.85	20,892.25

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

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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	08/01/15	THROUGH	07/31/16
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: 08/24/2017
 Run Time: 02:45:14
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,279,437.81	ADJUSTMENTS	976,228.37
COVERED CHARGES	22,969,303.78	CONTRACTUAL ALLOW	17,865,413.02
NON-COVERD CHARGES	310,134.03	TOTAL MEDICAID LIAB	5,103,890.76
		LESS: COB	75,258.57
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,028,632.19

TOTAL NUMBER OF ADMISSIONS 647

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,683		9	1,932,663.00		149,303.00
ROUTINE NURSERY	153		0	61,812.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,836		9	1,994,475.00		149,303.00
SPECIAL CARE SERVICES						
CCU	711		0	1,688,817.00		0.00
ICU	267		0	872,214.00		3,279.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	978		0	2,561,031.00		3,279.00
TOTAL ACCOMODATIONS	2,814		9	4,555,506.00		152,582.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,611,731.39	46,782.20	OTHER LAB	152,901.00	1,468.00
MED/SURG SUPPLY	890,782.82	11,944.08	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,408,819.00	17,569.00	EDUCATION & TRAINING	6,028.00	0.00
RADIOLOGY-DIAGNOSTIC	488,908.00	3,402.00	OTHER THERAPEUTIC SVC	0.00	1,110.00
CT SCAN	1,401,430.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	80,160.24	1,608.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	224,394.00	0.00	MRI SERVICES	339,395.00	0.00
IV THERAPY	420,891.00	393.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	984,758.00	2,205.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	557,883.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,914,274.00	36,866.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	412,679.00	2,136.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,200,337.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	165,274.00	264.00	DRUG-SPECIFIC/HOME IV	0.00	4,022.75
LABORATORY PATHOLOGIC	103,643.00	274.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	58,411.23	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,000,908.00	23,952.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	24,087.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	18,720.00	0.00	IMPL DEV CHARGE PATIENTS	134,623.64	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	177,587.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	329,928.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	201,414.00	282.00			
AUDIOLOGY	24,599.00	0.00			
CARDIOLOGY	931,849.00	3,274.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	55,302.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	92,080.46	0.00			
			TOTAL ANCILLARY	18,413,797.78	157,552.03
			TOTAL ACCOMODATIONS	4,555,506.00	152,582.00
			TOTAL CHARGES	22,969,303.78	310,134.03

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	440,369.92	ADJUSTMENTS	0.00
COVERED CHARGES	437,006.92	CONTRACTUAL ALLOW	235,264.47
NON-COVERD CHARGES	3,363.00	TOTAL MEDICAID LIAB	201,742.45
		LESS: COB	201,742.45
		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	57		0	66,747.00		3,363.00
ROUTINE NURSERY	2		0	808.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	59		0	67,555.00		3,363.00
SPECIAL CARE SERVICES						
CCU	15		0	34,425.00		0.00
ICU	1		0	3,279.00		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	16		0	37,704.00		0.00
TOTAL ACCOMODATIONS	75		0	105,259.00		3,363.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	117,417.00	0.00	OTHER LAB	264.00	0.00
MED/SURG SUPPLY	12,644.92	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	56,094.00	0.00	EDUCATION & TRAINING	156.00	0.00
RADIOLOGY-DIAGNOSTIC	5,243.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,311.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	709.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	894.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,733.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,951.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	14,858.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	44,606.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,136.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	27,888.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	66.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,371.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	333.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,296.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,381.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,038.00	0.00			
AUDIOLOGY	364.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,466.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	528.00	0.00			
			TOTAL ANCILLARY	331,747.92	0.00
			TOTAL ACCOMODATIONS	105,259.00	3,363.00
			TOTAL CHARGES	437,006.92	3,363.00

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,848,043.29	ADJUSTMENTS	151,931.89
COVERED CHARGES	16,278,879.40	CONTRACTUAL ALLOW	14,082,431.23
NON-COVERD CHARGES	1,569,163.89	TOTAL MEDICAID LIAB	2,196,448.17
		LESS: COB	31,845.21
		LESS: COPAYMENT	2,989.01
		REIMBURSEMENT	2,161,613.95
		ALL OTHER	1,925,663.49
		FEE SCHEDULE-LAB	194,410.92
		INJECTABLE DRUGS	41,539.54
		TOTAL NUMBER OF CLAIMS	5,620

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	333,007.69	12,909.00	OTHER LAB	283,398.00	1,799.00
MED/SURG SUPPLY	200,202.30	24,497.40	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	207.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,101,185.00	12,380.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,651,276.00	332,149.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	21,894.00	14,002.10	FEE SCHEDULE LAB	2,543,388.06	143,773.79
EKG/ECG	261,363.00	3,129.00	MRI SERVICES	560,771.00	150,097.00
IV THERAPY	792,284.00	225.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	692,792.00	65,724.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	63,198.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	75,196.00	78,075.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	329,473.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,332,676.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	140,505.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	253,474.79	434,256.25
RADIOLOGY THERAPEUTIC	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	3,196.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	19,019.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,745.00	8,214.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	28,950.00	80,694.00	IMPL DEV CHARGE PATIENTS	7,300.13	11,501.32
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	135.00
OTHER IMAGING SERVICE	564,390.00	60,518.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	25,176.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	276,953.00	19,332.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	317,559.00	92,126.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	227,923.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	185,403.43	1,205.00			
			TOTAL ANCILLARY	16,278,879.40	1,569,163.89
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,278,879.40	1,569,163.89

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3018	5915258000878	08/19/15 - 08/19/15	09/21/15	0.00	93.00	0.00	0.00	0.00
36	5916014000333	12/21/15 - 12/21/15	01/18/16	0.00	42.00	0.00	0.00	0.00
TOTAL				0.00	135.00	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

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

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	199,880.13	ADJUSTMENTS	0.00
COVERED CHARGES	177,773.49	CONTRACTUAL ALLOW	96,508.84
NON-COVERD CHARGES	22,106.64	TOTAL MEDICAID LIAB	81,264.65
		LESS: COB	81,231.42
		LESS: COPAYMENT	33.23
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 68

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,601.50	345.00	OTHER LAB	8,664.00	0.00
MED/SURG SUPPLY	1,441.32	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,318.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,969.00	11,153.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	34,826.20	589.64
EKG/ECG	1,788.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	14,274.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,917.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	278.00	944.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,136.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	57,579.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,946.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,618.25	64.00
RADIOLOGY THERAPEUTIC	198.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	601.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	1,100.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,569.00	7,911.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,812.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,785.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,452.22	0.00			
			TOTAL ANCILLARY	177,773.49	22,106.64
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	177,773.49	22,106.64

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: 08/24/2017
Run Time: 02:46:26
Page: 10

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

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	766,778.00	ADJUSTMENTS	323.64
COVERED CHARGES	740,513.00	CONTRACTUAL ALLOW	712,683.46
NON-COVERD CHARGES	26,265.00	TOTAL MEDICAID LIAB	27,829.54
		LESS: COB	810.52
		LESS: COPAYMENT	808.16
		REIMBURSEMENT	26,210.86

TOTAL NUMBER OF CLAIMS 483

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,794.50	377.00	OTHER LAB	22,063.00	0.00
MED/SURG SUPPLY	1,371.00	580.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	45,277.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	41,475.00	6,154.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	125,455.00	4,720.00
EKG/ECG	8,046.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	28,083.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,168.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,179.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	420,029.00	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	1,944.50	373.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	2,970.00	6,660.00	IMPL DEV CHARGE PATIENTS	0.00	1,100.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	21,658.00	6,301.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	740,513.00	26,265.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	740,513.00	26,265.00

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: 08/24/2017
Run Time: 02:46:30
Page: 12

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

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,435.50	ADJUSTMENTS	0.00
COVERED CHARGES	23,742.50	CONTRACTUAL ALLOW	12,175.30
NON-COVERD CHARGES	2,693.00	TOTAL MEDICAID LIAB	11,567.20
		LESS: COB	11,560.20
		LESS: COPAYMENT	7.00
		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

Run Date: 08/24/2017
 Run Time: 02:46:30
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	350.75	300.00	OTHER LAB	1,799.00	0.00
MED/SURG SUPPLY	128.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,154.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,962.00	222.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,168.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,272.00	2,171.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	131.75	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	777.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	23,742.50	2,693.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	23,742.50	2,693.00

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: 08/24/2017
Run Time: 02:46:31
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	437,939.01	ADJUSTMENTS	10,838.04
COVERED CHARGES	432,008.01	CONTRACTUAL ALLOW	377,283.53
NON-COVERD CHARGES	5,931.00	TOTAL MEDICAID LIAB	54,724.48
		LESS: COB	0.00
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	54,694.48
		TOTAL NUMBER OF CLAIMS	10

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,331.00	360.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,837.96	3,979.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	893.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,512.00	0.00
EKG/ECG	447.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	13,721.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	38,701.00	1.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	233.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,072.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	289,656.75	15.00
RADIOLOGY THERAPEUTIC	1,584.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	232.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,165.00	612.00
LITHOTRIPSY	39,761.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	25,350.00	964.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,511.30	0.00			
			TOTAL ANCILLARY	432,008.01	5,931.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	432,008.01	5,931.00

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: 08/24/2017
Run Time: 02:46:33
Page: 16

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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
 Run Time: 04:00:49
 Page: 1

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	395,035.20	ADJUSTMENTS	14,965.36
COVERED CHARGES	379,326.20	CONTRACTUAL ALLOW	203,368.61
NON-COVERD CHARGES	15,709.00	TOTAL MEDICAID LIAB	175,957.59
		LESS: COB	12,626.28
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	163,331.31

TOTAL NUMBER OF ADMISSIONS 34

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	151		0	81,540.00		12,025.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	151		0	81,540.00		12,025.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	151		0	81,540.00		12,025.00

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	64,208.20	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	33,898.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	71,389.00	0.00	EDUCATION & TRAINING	441.00	0.00
RADIOLOGY-DIAGNOSTIC	3,938.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	28,027.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,329.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	800.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,146.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,013.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,236.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,786.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	102.00	0.00	INJECTABLE DRUGS	25,434.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	244.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,873.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,524.00
OTHER IMAGING SERVICE	1,320.00	0.00			
BLOOD	4,746.00	0.00			
BLOOD STORAGE & PRO.	4,746.00	2,160.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,600.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,510.00	0.00			
			TOTAL ANCILLARY	297,786.20	3,684.00
			TOTAL ACCOMODATIONS	81,540.00	12,025.00
			TOTAL CHARGES	379,326.20	15,709.00

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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016076000394	02/25/16 - 03/02/16	03/21/16	0.00	1,524.00	0.00	0.00	0.00
TOTAL				0.00	1,524.00	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: 08/24/2017
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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	10/01/15	THROUGH	09/30/16
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: 08/24/2017
Run Time: 04:00:50
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	878,139.91	ADJUSTMENTS	19,723.83
COVERED CHARGES	809,500.91	CONTRACTUAL ALLOW	548,987.85
NON-COVERD CHARGES	68,639.00	TOTAL MEDICAID LIAB	260,513.06
		LESS: COB	0.00
		LESS: COPAYMENT	624.00
		REIMBURSEMENT	259,889.06
		ALL OTHER	226,609.19
		FEE SCHEDULE-LAB	20,000.87
		INJECTABLE DRUGS	13,279.00

TOTAL NUMBER OF CLAIMS 839

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: 08/24/2017
 Run Time: 04:00:50
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,646.71	770.00	OTHER LAB	2,588.00	0.00
MED/SURG SUPPLY	10,249.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	126.00
RADIOLOGY-DIAGNOSTIC	37,665.00	1,253.00	OTHER THERAPEUTIC SVC	0.00	315.00
CT SCAN	143,187.00	34,140.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	240,066.00	14,697.00
EKG/ECG	4,504.00	217.00	MRI SERVICES	0.00	0.00
IV THERAPY	15,785.00	80.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,844.00	3,936.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,606.00	2,078.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,068.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	243,324.00	2,541.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	42,161.20	6,756.00
RADIOLOGY THERAPEUTIC	120.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	170.00	170.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,344.00	0.00			
BLOOD	339.00	339.00			
BLOOD STORAGE & PRO.	339.00	1,059.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,200.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	15,295.00	162.00			
			TOTAL ANCILLARY	809,500.91	68,639.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	809,500.91	68,639.00

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

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,976.00	ADJUSTMENTS	0.00
COVERED CHARGES	9,299.00	CONTRACTUAL ALLOW	2,009.75
NON-COVERD CHARGES	677.00	TOTAL MEDICAID LIAB	7,289.25
		LESS: COB	7,289.25
		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

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	78.00	53.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	130.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	358.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,577.00	624.00
EKG/ECG	57.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,092.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,299.00	677.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,299.00	677.00

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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	94,777.76	ADJUSTMENTS	0.00
COVERED CHARGES	85,998.76	CONTRACTUAL ALLOW	80,898.76
NON-COVERD CHARGES	8,779.00	TOTAL MEDICAID LIAB	5,100.00
		LESS: COB	0.00
		LESS: COPAYMENT	189.00
		REIMBURSEMENT	4,911.00
		TOTAL NUMBER OF CLAIMS	102

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	535.00	140.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	449.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,253.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,944.00	7,265.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,314.00	572.00
EKG/ECG	80.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	89.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	55,113.00	657.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,221.76	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	85,998.76	8,779.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	85,998.76	8,779.00

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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,205.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,196.00	CONTRACTUAL ALLOW	1,193.00
NON-COVERD CHARGES	9.00	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

Run Date: 08/24/2017
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SUMMARY TYPE VI
 ZERO PAID 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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	9.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	37.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	9.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,196.00	9.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,196.00	9.00

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

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	47,971.00	ADJUSTMENTS	0.00
COVERED CHARGES	40,743.00	CONTRACTUAL ALLOW	31,017.22
NON-COVERD CHARGES	7,228.00	TOTAL MEDICAID LIAB	9,725.78
		LESS: COB	0.00
		LESS: COPAYMENT	60.00
		REIMBURSEMENT	9,665.78
		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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,027.00	486.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	102.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,074.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,515.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,210.00	1,572.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	994.00	4,450.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,222.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,243.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	1,356.00	0.00			
BLOOD STORAGE & PRO.	0.00	720.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	40,743.00	7,228.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	40,743.00	7,228.00

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: 08/24/2017
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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	10/01/15	THROUGH	09/30/16
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: 08/24/2017
 Run Time: 02:50:12
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	426,947.89	ADJUSTMENTS	48,768.91
COVERED CHARGES	336,075.34	CONTRACTUAL ALLOW	219,577.19
NON-COVERD CHARGES	90,872.55	TOTAL MEDICAID LIAB	116,498.15
		LESS: COB	2,157.57
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	114,340.58

TOTAL NUMBER OF ADMISSIONS 12

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	54		0	49,032.00		82,125.00
ROUTINE NURSERY	0		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	49,032.00		82,125.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	54		0	49,032.00		82,125.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	74,994.30	0.00	OTHER LAB	1,341.29	0.00
MED/SURG SUPPLY	11,174.42	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	32,571.96	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,475.51	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,759.02	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,244.91	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,082.84	0.00	MRI SERVICES	2,810.44	0.00
IV THERAPY	2,709.87	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	25,209.61	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,059.12	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,703.72	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,323.85	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,145.29	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,324.94	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,447.69	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	423.56	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	74.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	81,492.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	8,747.55			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,675.00	0.00			
			TOTAL ANCILLARY	287,043.34	8,747.55
			TOTAL ACCOMODATIONS	49,032.00	82,125.00
			TOTAL CHARGES	336,075.34	90,872.55

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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,066,276.48	ADJUSTMENTS	135,938.79
COVERED CHARGES	2,874,145.32	CONTRACTUAL ALLOW	2,114,460.29
NON-COVERD CHARGES	192,131.16	TOTAL MEDICAID LIAB	759,685.03
		LESS: COB	3,786.65
		LESS: COPAYMENT	1,368.00
		REIMBURSEMENT	754,530.38
		ALL OTHER	701,781.40
		FEE SCHEDULE-LAB	48,426.62
		INJECTABLE DRUGS	4,322.36
		TOTAL NUMBER OF CLAIMS	1,677

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	82,718.65	1,241.85	OTHER LAB	45,694.27	831.39
MED/SURG SUPPLY	34,189.11	165.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	313,874.32	11,399.83	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	451,275.22	80,340.95	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	18,807.11	1,431.87	FEE SCHEDULE LAB	507,554.99	24,061.47
EKG/ECG	46,301.81	270.71	MRI SERVICES	133,562.92	3,640.14
IV THERAPY	96,546.22	810.00	PROFESSIONAL FEES	0.00	265.36
OPERATING ROOM	48,109.62	4,414.08	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	23,817.54	2,503.80	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,663.45	0.00	AMBULANCE	0.00	0.00
GI SERVICES	43,591.07	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	799,885.99	1,762.29	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	23,563.70	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	40,495.11	22,166.75
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,599.78	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,517.60	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	781.70	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	4,381.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	86,048.87	28,333.40			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	921.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,100.83	1,349.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,961.14	1,980.57			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	51,345.00	0.00			
			TOTAL ANCILLARY	2,874,145.32	192,131.16
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,874,145.32	192,131.16

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

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	55,697.81	ADJUSTMENTS	0.00
COVERED CHARGES	48,423.05	CONTRACTUAL ALLOW	21,736.53
NON-COVERD CHARGES	7,274.76	TOTAL MEDICAID LIAB	26,686.52
		LESS: COB	26,668.54
		LESS: COPAYMENT	17.98
		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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,344.95	165.85	OTHER LAB	777.31	0.00
MED/SURG SUPPLY	515.87	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,785.47	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,503.63	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,306.39	1,254.60
EKG/ECG	270.71	0.00	MRI SERVICES	2,810.44	0.00
IV THERAPY	1,684.37	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,001.52	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	317.79	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	4,323.85	CAST ROOM	0.00	0.00
EMERGENCY ROOM	17,291.20	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	864.56	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	760.84	872.46
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	718.00	658.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,470.00	0.00			
			TOTAL ANCILLARY	48,423.05	7,274.76
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	48,423.05	7,274.76

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

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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	226,546.30	ADJUSTMENTS	97.00
COVERED CHARGES	218,793.50	CONTRACTUAL ALLOW	207,793.50
NON-COVERD CHARGES	7,752.80	TOTAL MEDICAID LIAB	11,000.00
		LESS: COB	0.00
		LESS: COPAYMENT	426.00
		REIMBURSEMENT	10,574.00
		TOTAL NUMBER OF CLAIMS	220

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,386.56	0.00	OTHER LAB	1,554.62	0.00
MED/SURG SUPPLY	728.69	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,859.90	1,518.33	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,978.54	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	19,728.45	1,732.55
EKG/ECG	270.71	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,335.23	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	751.14	250.38	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	147,532.67	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,478.98	1,022.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	53.54	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,188.01	3,176.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	218,793.50	7,752.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	218,793.50	7,752.80

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: 08/24/2017
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Page: 10

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,507.76	ADJUSTMENTS	0.00
COVERED CHARGES	6,475.66	CONTRACTUAL ALLOW	4,510.62
NON-COVERD CHARGES	32.10	TOTAL MEDICAID LIAB	1,965.04
		LESS: COB	1,965.04
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	331.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	25.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,381.37	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	436.02	32.10
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	173.40	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,099.17	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	29.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,475.66	32.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,475.66	32.10

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	47,935.51	ADJUSTMENTS	0.00
COVERED CHARGES	46,365.51	CONTRACTUAL ALLOW	40,564.78
NON-COVERD CHARGES	1,570.00	TOTAL MEDICAID LIAB	5,800.73
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	5,794.73

TOTAL NUMBER OF CLAIMS 1

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,642.61	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,786.83	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	717.51	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	608.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	26,967.21	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,455.31	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,164.61	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,321.43	377.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	585.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,310.00	0.00			
			TOTAL ANCILLARY	46,365.51	1,570.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	46,365.51	1,570.00

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: 08/24/2017
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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	07/01/15	THROUGH	06/30/16
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

ELBERT MEMORIAL HOSPITAL
 4 MEDICAL DR
 ELBERTON,GA 30635-1830

PROVIDER NUMBER 000000668A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	420,299.20	ADJUSTMENTS	42,960.33
COVERED CHARGES	410,057.70	CONTRACTUAL ALLOW	156,360.18
NON-COVERD CHARGES	10,241.50	TOTAL MEDICAID LIAB	253,697.52
		LESS: COB	2,632.97
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	251,064.55

TOTAL NUMBER OF ADMISSIONS 45

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	120		0	72,960.00		6,265.00
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	120		0	72,960.00		6,265.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	18		0	21,690.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	21,690.00		0.00
TOTAL ACCOMODATIONS	138		0	94,650.00		6,265.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	68,127.01	0.00	OTHER LAB	926.33	0.00
MED/SURG SUPPLY	16,814.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	80,019.84	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,998.69	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	42,093.28	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,396.00	0.00	MRI SERVICES	3,991.00	0.00
IV THERAPY	13,106.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,000.00	0.00	DURABLE MED. EQUIP.	0.00	271.50
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	20,337.19	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	273.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	32,295.52	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	1,192.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,037.00
OTHER IMAGING SERVICE	2,987.28	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,986.68	1,668.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,538.79	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,930.09	0.00			
			TOTAL ANCILLARY	315,407.70	3,976.50
			TOTAL ACCOMODATIONS	94,650.00	6,265.00
			TOTAL CHARGES	410,057.70	10,241.50

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

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

Run Date: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016152066641	05/18/16 - 05/21/16	06/06/16	0.00	2,037.00	0.00	0.00	0.00
TOTAL				0.00	2,037.00	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

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/15	THROUGH	06/30/16
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: 08/24/2017
Run Time: 02:50:45
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,102,370.86	ADJUSTMENTS	8,929.62
COVERED CHARGES	1,041,726.51	CONTRACTUAL ALLOW	766,676.85
NON-COVERD CHARGES	60,644.35	TOTAL MEDICAID LIAB	275,049.66
		LESS: COB	1,028.99
		LESS: COPAYMENT	956.01
		REIMBURSEMENT	273,064.66
		ALL OTHER	252,022.42
		FEE SCHEDULE-LAB	20,364.15
		INJECTABLE DRUGS	678.09

TOTAL NUMBER OF CLAIMS 864

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: 08/24/2017
 Run Time: 02:50:45
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,288.20	2,826.49	OTHER LAB	12,212.76	0.00
MED/SURG SUPPLY	8,238.80	587.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	78,386.60	2,078.70	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	204,983.32	20,419.98	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	17,404.90	7,844.77	FEE SCHEDULE LAB	181,550.51	2,707.56
EKG/ECG	14,545.13	0.00	MRI SERVICES	37,902.12	0.00
IV THERAPY	48,687.37	8,523.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	28,500.00	1,500.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,824.96	2,191.83	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,071.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	271,688.76	3,917.91	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,198.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,179.15	3,657.95
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	51,555.78	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,043.49	1,112.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	8,957.00	1,591.29			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,077.59	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	10,867.39	1,685.12			
			TOTAL ANCILLARY	1,041,726.51	60,644.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,041,726.51	60,644.35

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,832.25	ADJUSTMENTS	0.00
COVERED CHARGES	11,043.47	CONTRACTUAL ALLOW	5,936.44
NON-COVERD CHARGES	4,788.78	TOTAL MEDICAID LIAB	5,107.03
		LESS: COB	5,106.13
		LESS: COPAYMENT	0.90
		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

ELBERT MEMORIAL HOSPITAL
 4 MEDICAL DR
 ELBERTON,GA 30635-1830

PROVIDER NUMBER
 000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	103.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	42.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	471.76	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,875.56	4,220.66	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,543.52	54.12
EKG/ECG	328.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	993.65	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,838.36	454.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	168.00	60.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	679.62	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	11,043.47	4,788.78
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,043.47	4,788.78

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	70,993.61	ADJUSTMENTS	108.88
COVERED CHARGES	70,245.48	CONTRACTUAL ALLOW	66,385.62
NON-COVERD CHARGES	748.13	TOTAL MEDICAID LIAB	3,859.86
		LESS: COB	13.60
		LESS: COPAYMENT	162.00
		REIMBURSEMENT	3,684.26
		TOTAL NUMBER OF CLAIMS	69

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	665.01	396.10	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	72.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,210.62	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,969.79	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,916.25	352.03
EKG/ECG	820.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,988.42	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	81.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	29,144.72	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	188.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	189.67	0.00			
			TOTAL ANCILLARY	70,245.48	748.13
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	70,245.48	748.13

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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ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/15	THROUGH	06/30/16
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

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/15	THROUGH	06/30/16
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

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/15	THROUGH	06/30/16
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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,904,845.61	ADJUSTMENTS	195,451.70
COVERED CHARGES	2,666,896.11	CONTRACTUAL ALLOW	1,802,787.25
NON-COVERD CHARGES	237,949.50	TOTAL MEDICAID LIAB	864,108.86
		LESS: COB	8,390.72
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	855,718.14

TOTAL NUMBER OF ADMISSIONS 138

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	611		0	303,309.00		229,783.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	611		0	303,309.00		229,783.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	100		0	110,200.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	100		0	110,200.00		0.00
TOTAL ACCOMODATIONS	711		0	413,509.00		229,783.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	915,677.46	1,801.50	OTHER LAB	5,474.00	0.00
MED/SURG SUPPLY	71,540.83	43.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	438,907.96	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	67,937.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	114,345.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	12,204.51	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	29,494.00	0.00	MRI SERVICES	23,498.00	0.00
IV THERAPY	34,149.00	0.00	PROFESSIONAL FEES	0.00	520.00
OPERATING ROOM	39,970.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	231,565.10	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,968.20	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	178,433.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	16,470.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,854.05	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,904.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	152.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,493.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,068.00	5,802.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	23,870.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,412.00	0.00			
			TOTAL ANCILLARY	2,253,387.11	8,166.50
			TOTAL ACCOMODATIONS	413,509.00	229,783.00
			TOTAL CHARGES	2,666,896.11	237,949.50

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

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

Run Date: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
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: 08/24/2017
Run Time: 02:51:05
Page: 4

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,958,494.16	ADJUSTMENTS	21,952.29
COVERED CHARGES	4,676,840.72	CONTRACTUAL ALLOW	4,061,795.72
NON-COVERD CHARGES	281,653.44	TOTAL MEDICAID LIAB	615,045.00
		LESS: COB	1,607.11
		LESS: COPAYMENT	1,203.00
		REIMBURSEMENT	612,234.89
		ALL OTHER	537,756.61
		FEE SCHEDULE-LAB	74,440.45
		INJECTABLE DRUGS	37.83
		TOTAL NUMBER OF CLAIMS	2,150

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: 08/24/2017
 Run Time: 02:51:05
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	276,538.55	100,690.70	OTHER LAB	31,872.00	0.00
MED/SURG SUPPLY	128,937.32	3,620.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	2,525.96	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	276,353.00	692.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	561,636.00	26,805.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	273.17	FEE SCHEDULE LAB	1,009,878.30	73,240.96
EKG/ECG	42,728.00	276.00	MRI SERVICES	148,401.00	4,636.00
IV THERAPY	275,245.00	2,981.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	97,212.00	9,176.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	22,301.40	2,079.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,315.60	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,321,652.00	15,717.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	50,142.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,931.90	3,535.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	164.90	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	2,025.60	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	2,848.40
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	117,893.00	3,281.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,471.00	2,127.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	14,270.00	9,914.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	12,253.90	6,820.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	20,294.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	247,514.00	8,224.00			
			TOTAL ANCILLARY	4,676,840.72	281,653.44
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,676,840.72	281,653.44

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

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

Run Date: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	99,307.74	ADJUSTMENTS	0.00
COVERED CHARGES	86,867.05	CONTRACTUAL ALLOW	46,785.90
NON-COVERD CHARGES	12,440.69	TOTAL MEDICAID LIAB	40,081.15
		LESS: COB	40,068.27
		LESS: COPAYMENT	12.88
		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

EMANUEL MEDICAL CENTER
 117 KITE RD
 SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
 000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,711.50	1,013.00	OTHER LAB	1,636.00	0.00
MED/SURG SUPPLY	4,074.70	72.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,045.00	373.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,217.00	6,586.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,292.50	1,660.09
EKG/ECG	1,394.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,236.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,970.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	634.75	193.60	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,244.60	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	29,062.00	1,496.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,830.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	519.00	81.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	966.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	86,867.05	12,440.69
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	86,867.05	12,440.69

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: 08/24/2017
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Page: 8

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	537,611.48	ADJUSTMENTS	214.76
COVERED CHARGES	515,343.32	CONTRACTUAL ALLOW	498,896.96
NON-COVERD CHARGES	22,268.16	TOTAL MEDICAID LIAB	16,446.36
		LESS: COB	0.00
		LESS: COPAYMENT	495.00
		REIMBURSEMENT	15,951.36
		TOTAL NUMBER OF CLAIMS	294

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,920.15	12,027.60	OTHER LAB	979.00	0.00
MED/SURG SUPPLY	5,922.26	269.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	631.49	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,713.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	60,336.00	3,116.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	82,742.06	5,889.07
EKG/ECG	1,670.00	0.00	MRI SERVICES	4,868.00	0.00
IV THERAPY	33,119.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,209.85	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	269,395.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	922.00	243.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	92.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,247.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,300.00	0.00			
			TOTAL ANCILLARY	515,343.32	22,268.16
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	515,343.32	22,268.16

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

EMANUEL MEDICAL CENTER
 117 KITE RD
 SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
 000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,848.60	ADJUSTMENTS	0.00
COVERED CHARGES	10,729.50	CONTRACTUAL ALLOW	6,568.87
NON-COVERD CHARGES	119.10	TOTAL MEDICAID LIAB	4,160.63
		LESS: COB	4,148.63
		LESS: COPAYMENT	12.00
		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

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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	626.00	97.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	1,688.50	22.10
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	280.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,255.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	461.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	10,729.50	119.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,729.50	119.10

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	07/01/15	THROUGH	06/30/16
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

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/15	THROUGH	06/30/16
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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	114,137,953.54	ADJUSTMENTS	10,066,081.23
COVERED CHARGES	109,041,855.69	CONTRACTUAL ALLOW	73,861,664.61
NON-COVERD CHARGES	5,096,097.85	TOTAL MEDICAID LIAB	35,180,191.08
		LESS: COB	231,769.57
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	34,948,421.51

TOTAL NUMBER OF ADMISSIONS 1,612

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	8,078		20	10,799,965.00		808,962.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		4,275.00
TOTAL ROUTINE	8,078		20	10,799,965.00		813,237.00
SPECIAL CARE SERVICES						
CCU	204		0	994,500.00		0.00
ICU	4,784		28	15,712,178.00		384,660.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		22	0.00		42,570.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	4,988		50	16,706,678.00		427,230.00
TOTAL ACCOMODATIONS	13,066		70	27,506,643.00		1,240,467.00

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,698,708.19	185,122.17	OTHER LAB	683,669.00	3,934.00
MED/SURG SUPPLY	3,879,318.72	159,306.40	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,284,715.00	232,952.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,656,570.00	14,411.00	OTHER THERAPEUTIC SVC	0.00	28,910.00
CT SCAN	3,856,315.00	55,074.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	731,485.02	5,638.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	344,917.00	1,022.00	MRI SERVICES	2,998,440.00	34,020.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,644,992.00	52,114.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,630,381.00	30,075.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,910,796.00	11,970.00	AMBULANCE	0.00	0.00
GI SERVICES	429,968.00	3,372.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,409,519.00	9,128.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	781,137.00	2,021.00	DRUG-SPECIFIC/HOME IV	0.00	474,001.99
LABORATORY PATHOLOGIC	824,051.00	20,855.00	INJECTABLE DRUGS	21,943,908.32	1,531,402.29
RADIOLOGY THERAPEUTIC	132,972.00	9,192.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	490,814.28	8,527.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	277,300.67	4,630.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	503,652.00	121,304.00	PATIENT CONVENIENCE	0.00	191.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	131.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,402,260.99	53,194.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	456,803.00
OTHER IMAGING SERVICE	241,152.00	143,996.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,557,236.00	114,651.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	73,269.00	82,898.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,875,566.00	4,916.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,363,415.00	0.00			
ORGAN ACQUISITION	1,877,038.50	0.00			
TREATMENT/OBSERV. RM	31,515.00	0.00			
			TOTAL ANCILLARY	81,535,212.69	3,855,630.85
			TOTAL ACCOMODATIONS	27,506,643.00	1,240,467.00
			TOTAL CHARGES	109,041,855.69	5,096,097.85

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5915311000001	09/03/15 - 09/12/15	11/16/15	0.00	3,181.00	0.00	0.00	0.00
615	2015324075305	11/10/15 - 11/11/15	11/30/15	0.00	12,440.00	0.00	0.00	0.00
615	2015340001372	11/19/15 - 11/21/15	12/14/15	0.00	6,220.00	0.00	0.00	0.00
615	2015346001751	11/16/15 - 11/21/15	12/21/15	0.00	9,401.00	0.00	0.00	0.00
615	2015349058916	11/25/15 - 11/28/15	12/21/15	0.00	6,362.00	0.00	0.00	0.00
615	5215356000148	10/03/15 - 11/11/15	12/28/15	0.00	9,401.00	0.00	0.00	0.00
615	2015357105539	12/09/15 - 12/11/15	12/28/15	0.00	9,401.00	0.00	0.00	0.00
615	5215363004309	10/05/15 - 10/15/15	02/22/16	0.00	12,440.00	0.00	0.00	0.00
615	2015365001188	12/07/15 - 12/15/15	01/04/16	0.00	6,362.00	0.00	0.00	0.00
615	2016014079312	12/22/15 - 12/23/15	01/18/16	0.00	9,401.00	0.00	0.00	0.00
615	2016027095750	01/01/16 - 01/22/16	02/01/16	0.00	6,220.00	0.00	0.00	0.00
615	2016027095849	11/29/15 - 01/01/16	02/01/16	0.00	12,440.00	0.00	0.00	0.00
615	2016035095725	01/11/16 - 01/23/16	02/08/16	0.00	3,181.00	0.00	0.00	0.00
615	2016037025592	01/17/16 - 01/21/16	02/15/16	0.00	12,440.00	0.00	0.00	0.00
615	2016058025624	10/26/15 - 10/28/15	03/07/16	0.00	12,440.00	0.00	0.00	0.00
615	2016061053913	01/23/16 - 02/05/16	03/07/16	0.00	12,440.00	0.00	0.00	0.00
615	2216074006901	10/05/15 - 10/08/15	03/21/16	0.00	12,440.00	0.00	0.00	0.00
615	2216075007903	12/23/15 - 12/28/15	03/21/16	0.00	12,440.00	0.00	0.00	0.00
614	2316081000067	11/18/15 - 11/20/15	05/02/16	0.00	6,960.00	0.00	260.91	0.00
615	2016082068963	03/04/16 - 03/10/16	03/28/16	0.00	3,181.00	0.00	0.00	0.00
615	5216085000233	01/04/16 - 02/01/16	04/04/16	0.00	3,181.00	0.00	0.00	0.00
615	2016097078569	01/24/16 - 02/18/16	04/11/16	0.00	12,440.00	0.00	0.00	0.00
615	2016097078601	02/16/16 - 03/11/16	04/11/16	0.00	3,181.00	0.00	0.00	0.00
614	2216113009671	01/01/16 - 03/16/16	04/25/16	0.00	13,920.00	0.00	0.00	0.00
615	2016125087122	04/27/16 - 04/29/16	05/09/16	0.00	3,181.00	0.00	0.00	0.00
615	2016136001070	05/06/16 - 05/10/16	05/23/16	0.00	6,362.00	0.00	0.00	0.00
615	5916137000086	04/01/16 - 04/13/16	06/06/16	0.00	3,181.00	0.00	0.00	0.00
615	2316146000242	09/16/15 - 09/21/15	06/13/16	0.00	12,440.00	0.00	0.00	0.00
615	2016153061788	05/04/16 - 05/19/16	06/06/16	0.00	6,362.00	0.00	0.00	0.00
614	2016153061904	09/20/15 - 10/08/15	06/06/16	0.00	6,960.00	0.00	0.00	0.00
615	2016154098667	10/04/15 - 10/07/15	06/06/16	0.00	12,440.00	0.00	0.00	0.00
615	2016160064263	05/28/16 - 05/30/16	06/13/16	0.00	6,362.00	0.00	0.00	0.00
614	2316175000135	02/12/16 - 02/24/16	07/18/16	0.00	20,838.00	0.00	4,129.34	0.00
614	2216182007506	10/23/15 - 12/02/15	07/04/16	0.00	10,708.00	0.00	0.00	0.00
615	2016185000578	06/22/16 - 06/28/16	07/11/16	0.00	3,181.00	0.00	0.00	0.00
615	2016187046904	06/21/16 - 06/27/16	07/11/16	0.00	3,181.00	0.00	0.00	0.00
615	2216194005839	06/01/16 - 06/22/16	07/18/16	0.00	3,181.00	0.00	0.00	0.00
615	2016216076982	06/09/16 - 06/30/16	08/08/16	0.00	9,401.00	0.00	0.00	0.00
615	2316232000128	10/27/15 - 11/30/15	09/05/16	0.00	9,401.00	0.00	0.00	0.00
615	2016250065336	03/20/16 - 03/31/16	09/12/16	0.00	3,181.00	0.00	0.00	0.00
614	2016257052300	03/31/16 - 04/28/16	09/19/16	0.00	3,067.00	0.00	0.00	0.00
615	2016259082722	08/11/16 - 08/22/16	09/19/16	0.00	12,440.00	0.00	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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CLM#	CLM#	CLM#	CLM#	CLM#	CLM#	CLM#	CLM#	CLM#
615	2216279013899	07/19/16 - 07/20/16	10/10/16	0.00	12,440.00	0.00	0.00	0.00
614	2316284000002	05/11/16 - 05/14/16	11/21/16	0.00	6,960.00	0.00	3,157.46	0.00
615	2216299010684	05/16/16 - 07/08/16	10/31/16	0.00	12,724.00	0.00	0.00	0.00
615	5216328000221	03/28/16 - 04/29/16	11/28/16	0.00	6,220.00	0.00	0.00	0.00
614	2316355000115	07/21/16 - 07/30/16	01/23/17	0.00	13,920.00	0.00	2,734.93	0.00
615	2016355094260	09/14/15 - 09/17/15	12/26/16	0.00	9,401.00	0.00	0.00	0.00
614	5216363000157	07/16/16 - 08/04/16	01/02/17	0.00	6,960.00	0.00	0.00	0.00
615	5216363000157	07/16/16 - 08/04/16	01/02/17	0.00	6,220.00	0.00	0.00	0.00
615	2317018000334	03/27/16 - 04/29/16	02/06/17	0.00	3,181.00	0.00	0.00	0.00
615	2317019000071	04/10/16 - 04/18/16	02/20/17	0.00	12,440.00	0.00	5,001.08	0.00
615	2317074000343	08/09/16 - 08/13/16	04/03/17	0.00	3,181.00	0.00	0.00	0.00
615	2217087011540	04/27/16 - 05/05/16	04/03/17	0.00	3,181.00	0.00	0.00	0.00
615	2217111016166	06/27/16 - 09/21/16	04/24/17	0.00	3,181.00	0.00	0.00	0.00
614	5217198000253	10/05/15 - 11/07/15	07/24/17	0.00	3,138.00	0.00	0.00	0.00
614	5217234000020	12/16/15 - 03/05/16	01/01/00	0.00	6,276.00	0.00	0.00	0.00
TOTAL				0.00	456,803.00	0.00	15,283.72	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

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,647,516.49	ADJUSTMENTS	0.00
COVERED CHARGES	1,639,405.49	CONTRACTUAL ALLOW	840,424.49
NON-COVERD CHARGES	8,111.00	TOTAL MEDICAID LIAB	798,981.00
		LESS: COB	798,981.00
		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	101		0	136,445.00		7,480.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	101		0	136,445.00		7,480.00
SPECIAL CARE SERVICES						
CCU	7		0	34,125.00		0.00
ICU	44		0	149,820.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	51		0	183,945.00		0.00
TOTAL ACCOMODATIONS	152		0	320,390.00		7,480.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

EMORY UNIV HOSPPT FINANCIALSERV
 1364 CLIFTON RD NE DEPT RM
 ATLANTA,GA 30322-1059

PROVIDER NUMBER
 000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55,107.01	0.00	OTHER LAB	6,305.00	0.00
MED/SURG SUPPLY	45,240.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	166,263.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	23,583.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	71,238.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,157.04	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	5,738.00	0.00	MRI SERVICES	70,775.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	249,682.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	27,599.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	31,749.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,622.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	17,255.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,184.00	0.00	INJECTABLE DRUGS	237,386.43	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,491.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,535.01	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	147,946.00	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.	15,238.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,722.00	631.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	57,547.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	51,460.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,319,015.49	631.00
			TOTAL ACCOMODATIONS	320,390.00	7,480.00
			TOTAL CHARGES	1,639,405.49	8,111.00

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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,073,339.90	ADJUSTMENTS	487,698.44
COVERED CHARGES	18,006,584.34	CONTRACTUAL ALLOW	14,577,278.45
NON-COVERD CHARGES	8,066,755.56	TOTAL MEDICAID LIAB	3,429,305.89
		LESS: COB	8,714.87
		LESS: COPAYMENT	9,880.37
		REIMBURSEMENT	3,410,710.65
		ALL OTHER	2,614,398.31
		FEE SCHEDULE-LAB	746,012.64
		INJECTABLE DRUGS	50,299.70

TOTAL NUMBER OF CLAIMS 11,288

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	139,544.43	429,695.37	OTHER LAB	188,918.00	257.00
MED/SURG SUPPLY	516,799.39	172.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,395.00	EDUCATION & TRAINING	0.00	3,304.00
RADIOLOGY-DIAGNOSTIC	594,442.00	304,852.00	OTHER THERAPEUTIC SVC	219,212.00	328,698.00
CT SCAN	1,843,771.00	1,062,323.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	300.00	12,520.06	FEE SCHEDULE LAB	4,404,356.00	587,156.46
EKG/ECG	127,312.00	2,774.00	MRI SERVICES	2,977,821.00	1,665,118.00
IV THERAPY	1,860.00	2,846.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,142,208.50	491,782.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	30,769.00	3,270.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	261,098.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	98,353.00	68,851.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,621,242.00	23,905.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	296,836.00	608.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	416,164.76	939,710.92
RADIOLOGY THERAPEUTIC	8,775.00	742.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	378.00	4,288.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	558.00	1,971.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	56,813.00	PATIENT CONVENIENCE	0.00	62.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	3,336.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	168,428.26	673,417.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	52,879.00
OTHER IMAGING SERVICE	770,849.00	501,982.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	104,290.00	480.00			
ONCOLOGY	0.00	7,024.00			
NUCLEAR MEDICINE	172,954.00	315,893.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	616,800.00	492,028.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	17,742.00	0.00			
ORGAN ACQUISITION	0.00	19,368.75			
TREATMENT/OBSERV. RM	264,803.00	2,358.00			
			TOTAL ANCILLARY	18,006,584.34	8,061,880.56
			TOTAL ACCOMODATIONS	0.00	4,875.00
			TOTAL CHARGES	18,006,584.34	8,066,755.56

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

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015292029581	10/06/15 - 10/06/15	10/26/15	0.00	6,220.00	0.00	0.00	0.00
615	2015292029591	10/09/15 - 10/09/15	10/26/15	0.00	6,220.00	0.00	0.00	0.00
614	5915356001024	09/10/15 - 09/10/15	12/28/15	0.00	3,067.00	0.00	0.00	0.00
614	5915356001024	09/10/15 - 09/10/15	12/28/15	0.00	3,067.00	0.00	0.00	0.00
615	2016031018772	01/15/16 - 01/15/16	02/08/16	0.00	3,181.00	0.00	0.00	0.00
615	2016040070075	02/01/16 - 02/01/16	02/15/16	0.00	6,220.00	0.00	0.00	0.00
615	2016091031626	03/23/16 - 03/23/16	04/04/16	0.00	6,220.00	0.00	0.00	0.00
615	5916099001170	01/03/16 - 01/03/16	04/11/16	0.00	6,220.00	0.00	0.00	0.00
615	2016139086756	05/11/16 - 05/11/16	05/23/16	0.00	6,220.00	0.00	0.00	0.00
8708	5916160001359	04/27/16 - 04/27/16	06/13/16	0.00	24.00	0.00	0.00	0.00
615	2016217094464	07/28/16 - 07/28/16	08/08/16	0.00	6,220.00	0.00	0.00	0.00
TOTAL				0.00	52,879.00	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: 08/24/2017
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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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,018,648.09	ADJUSTMENTS	0.00
COVERED CHARGES	350,468.30	CONTRACTUAL ALLOW	-41,089.91
NON-COVERD CHARGES	668,179.79	TOTAL MEDICAID LIAB	391,558.21
		LESS: COB	391,230.73
		LESS: COPAYMENT	327.48
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 172

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,047.13	17,014.06	OTHER LAB	1,752.00	70.00
MED/SURG SUPPLY	21,301.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	56.00
RADIOLOGY-DIAGNOSTIC	16,737.00	13,060.00	OTHER THERAPEUTIC SVC	0.00	20,174.00
CT SCAN	23,029.00	47,082.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,214.00	FEE SCHEDULE LAB	74,356.00	6,939.00
EKG/ECG	2,862.00	292.00	MRI SERVICES	36,263.00	199,113.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	21,413.00	78,444.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	830.00	982.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	21,774.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,530.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	42,584.00	1,005.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	16,074.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,691.17	30,470.73
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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	105.00	122,897.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	15,578.00
OTHER IMAGING SERVICE	9,891.00	40,519.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,655.00	21,721.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	28,620.00	51,187.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,954.00	362.00			
			TOTAL ANCILLARY	350,468.30	668,179.79
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	350,468.30	668,179.79

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: 08/24/2017
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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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016152070814	10/18/15 - 10/18/15	06/06/16	0.00	6,220.00	0.00	4,822.00	0.00
615	2016152070814	10/18/15 - 10/18/15	06/06/16	0.00	6,220.00	0.00	4,822.00	0.00
614	2016168079723	01/04/16 - 01/04/16	06/20/16	0.00	3,138.00	0.00	1,280.00	0.00
TOTAL				0.00	15,578.00	0.00	10,924.00	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: 08/24/2017
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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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	148,086.98	ADJUSTMENTS	52.94
COVERED CHARGES	122,142.93	CONTRACTUAL ALLOW	117,051.30
NON-COVERD CHARGES	25,944.05	TOTAL MEDICAID LIAB	5,091.63
		LESS: COB	0.00
		LESS: COPAYMENT	233.82
		REIMBURSEMENT	4,857.81
		TOTAL NUMBER OF CLAIMS	92

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	251.58	38.10	OTHER LAB	2,909.00	0.00
MED/SURG SUPPLY	1,308.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,243.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,113.00	20,126.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	27,525.00	192.00
EKG/ECG	1,606.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	523.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	61,922.00	395.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,498.35	2,248.95
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	27.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,487.00	2,297.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,751.00	620.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	534.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	472.00	0.00			
			TOTAL ANCILLARY	122,142.93	25,944.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	122,142.93	25,944.05

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 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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,357.23	ADJUSTMENTS	0.00
COVERED CHARGES	1,357.23	CONTRACTUAL ALLOW	695.72
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	661.51
		LESS: COB	658.51
		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: 08/24/2017
 Run Time: 02:54:46
 Page: 16

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8.23	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	12.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	106.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,231.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,357.23	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,357.23	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: 08/24/2017
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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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,691,936.67	ADJUSTMENTS	83,821.00
COVERED CHARGES	1,417,018.75	CONTRACTUAL ALLOW	1,194,291.05
NON-COVERD CHARGES	274,917.92	TOTAL MEDICAID LIAB	222,727.70
		LESS: COB	6,861.90
		LESS: COPAYMENT	117.76
		REIMBURSEMENT	215,748.04

TOTAL NUMBER OF CLAIMS 34

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,127.50	1,564.99	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	117,933.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	85,079.00	67,717.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	680.00	2,409.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	19,962.00	552.00
EKG/ECG	438.00	44.00	MRI SERVICES	0.00	3,049.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	410,877.00	64,252.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	645.00	129.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	44,745.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	727.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,594.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	105,474.06	10,029.93
RADIOLOGY THERAPEUTIC	3,616.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	397,060.19	67,912.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	99.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	15,123.00	6,902.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	186,074.00	50,357.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,765.00	0.00			
			TOTAL ANCILLARY	1,417,018.75	274,917.92
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,417,018.75	274,917.92

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: 08/24/2017
Run Time: 02:54:52
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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	09/01/15	THROUGH	08/31/16
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: 08/24/2017
 Run Time: 03:34:40
 Page: 1

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

AU MEDICAL CENTER, INC
 1120 15TH ST
 AUGUSTA,GA 30912-0004

PROVIDER NUMBER 000000723A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	129,570,460.75	ADJUSTMENTS	10,470,867.22
COVERED CHARGES	125,005,541.82	CONTRACTUAL ALLOW	92,298,579.74
NON-COVERD CHARGES	4,564,918.93	TOTAL MEDICAID LIAB	32,706,962.08
		LESS: COB	230,405.30
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	32,476,556.78

TOTAL NUMBER OF ADMISSIONS 2,411

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	11,148	70	8,598,132.00	1,605,092.00
ROUTINE NURSERY	686	0	786,798.00	296,000.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	7.11
TOTAL ROUTINE	11,834	70	9,384,930.00	1,901,099.11
SPECIAL CARE SERVICES				
CCU	141	0	257,400.00	0.00
ICU	2,142	0	4,471,004.00	36,958.00
NICU	678	0	2,627,612.00	7,774.00
PED ICU	531	0	1,834,527.00	116,610.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	429	0	1,471,899.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	3,921	0	10,662,442.00	161,342.00
TOTAL ACCOMODATIONS	15,755	70	20,047,372.00	2,062,441.11

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

AU MEDICAL CENTER, INC
 1120 15TH ST
 AUGUSTA,GA 30912-0004

PROVIDER NUMBER
 000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,109,884.71	446,502.20	OTHER LAB	512,510.98	13,675.00
MED/SURG SUPPLY	11,962,462.00	321,187.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	17,558,701.71	440,352.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,911,952.00	45,492.00	OTHER THERAPEUTIC SVC	0.00	34,672.00
CT SCAN	3,293,699.00	126,565.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	731,060.14	20,920.10	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	243,013.96	948.00	MRI SERVICES	1,036,837.00	25,240.00
IV THERAPY	755,653.00	15,733.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,629,034.00	92,537.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	406,945.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,533,273.02	213,089.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,921,916.00	29,381.00	AMBULANCE	0.00	0.00
GI SERVICES	317,217.00	6,032.00	CAST ROOM	668.00	0.00
EMERGENCY ROOM	2,269,798.00	1,928.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	700,179.00	4,212.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,011,079.00	8,760.00	INJECTABLE DRUGS	5,773,801.31	140,779.88
RADIOLOGY THERAPEUTIC	148,785.00	3,035.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	316,687.16	5,351.12	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	247,094.84	9,693.02	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	331,848.00	64,111.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	194.00	43,823.00	TRAUMA RESPONSE	0.00	174,161.00
PSYCHIATRIC SERVICES	17,803.00	0.00	IMPL DEV CHARGE PATIENTS	7,812,842.00	48,661.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	528,455.00	31,294.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,262,680.00	118,230.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	100,432.00	1,456.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,035,835.99	7,888.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,163,817.00	6,769.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	312,011.00	0.00			
			TOTAL ANCILLARY	104,958,169.82	2,502,477.82
			TOTAL ACCOMODATIONS	20,047,372.00	2,062,441.11
			TOTAL CHARGES	125,005,541.82	4,564,918.93

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

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

Run Date: 08/24/2017
 Run Time: 03:35:12
 Page: 3

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

AU MEDICAL CENTER, INC
 1120 15TH ST
 AUGUSTA,GA 30912-0004

PROVIDER NUMBER 000000723A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,011,054.59	ADJUSTMENTS	0.00
COVERED CHARGES	1,987,922.59	CONTRACTUAL ALLOW	1,100,529.88
NON-COVERD CHARGES	23,132.00	TOTAL MEDICAID LIAB	887,392.71
		LESS: COB	887,392.71
		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	97		0	76,824.00		7,748.00
ROUTINE NURSERY	24		0	20,980.00		14,800.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	121		0	97,804.00		22,548.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	19		0	31,016.00		0.00
NICU	5		0	19,435.00		0.00
PED ICU	42		0	148,890.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	66		0	199,341.00		0.00
TOTAL ACCOMODATIONS	187		0	297,145.00		22,548.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

AU MEDICAL CENTER, INC
 1120 15TH ST
 AUGUSTA,GA 30912-0004

PROVIDER NUMBER
 000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	203,467.76	0.00	OTHER LAB	2,090.00	0.00
MED/SURG SUPPLY	219,028.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	200,306.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	29,871.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,778.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,156.06	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,738.00	0.00	MRI SERVICES	18,795.00	0.00
IV THERAPY	2,985.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	120,890.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	211,223.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	60,461.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,000.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,696.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,885.00	0.00	INJECTABLE DRUGS	121,495.73	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,334.04	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	584.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	221,038.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,993.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,137.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	119,720.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	94,690.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,690,777.59	584.00
			TOTAL ACCOMODATIONS	297,145.00	22,548.00
			TOTAL CHARGES	1,987,922.59	23,132.00

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: 08/24/2017
Run Time: 03:35:20
Page: 5

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	65,958,735.61	ADJUSTMENTS	1,777,034.30
COVERED CHARGES	57,755,976.30	CONTRACTUAL ALLOW	46,315,710.63
NON-COVERD CHARGES	8,202,759.31	TOTAL MEDICAID LIAB	11,440,265.67
		LESS: COB	45,006.17
		LESS: COPAYMENT	55,971.25
		REIMBURSEMENT	11,339,288.25
		ALL OTHER	9,105,851.86
		FEE SCHEDULE-LAB	783,268.32
		INJECTABLE DRUGS	1,450,168.07

TOTAL NUMBER OF CLAIMS 35,203

SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

AU MEDICAL CENTER, INC
 1120 15TH ST
 AUGUSTA,GA 30912-0004

PROVIDER NUMBER
 000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,049,201.84	373,613.18	OTHER LAB	932,536.00	22,863.00
MED/SURG SUPPLY	1,929,074.00	34,640.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,660.22	EDUCATION & TRAINING	0.00	1,080.00
RADIOLOGY-DIAGNOSTIC	1,877,059.42	12,533.00	OTHER THERAPEUTIC SVC	0.00	16,158.00
CT SCAN	2,803,495.00	716,434.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	78,639.00	49,625.04	FEE SCHEDULE LAB	8,868,570.26	381,007.22
EKG/ECG	289,834.00	3,318.00	MRI SERVICES	1,786,232.00	377,110.00
IV THERAPY	1,151,123.00	11,540.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,409,791.77	958,315.72	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,727.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	747,403.27	100,177.77	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,900,443.00	1,531.00	AMBULANCE	0.00	0.00
GI SERVICES	594,916.14	77,962.80	CAST ROOM	22,133.00	2,254.00
EMERGENCY ROOM	4,250,750.00	12,162.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,192,863.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	2,034.00	INJECTABLE DRUGS	8,457,379.36	3,338,564.25
RADIOLOGY THERAPEUTIC	2,428,980.00	313,260.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	26,987.00	28,320.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	18,492.00	23,075.48	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	39,557.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,616,852.00	24,250.53	TRAUMA RESPONSE	0.00	149,249.00
PSYCHIATRIC SERVICES	42,838.00	22,587.00	IMPL DEV CHARGE PATIENTS	501,614.00	147,089.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,096,929.00	278,251.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	416,724.00	0.00			
ONCOLOGY	61,110.00	1,165.00			
NUCLEAR MEDICINE	452,079.00	54,743.50			
AUDIOLOGY	6,178.00	9,395.00			
CARDIOLOGY	1,146,848.67	591,253.58			
AMBULATORY SURGERY	0.00	2,496.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	860,271.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	734,902.57	22,543.00			
			TOTAL ANCILLARY	57,755,976.30	8,201,818.31
			TOTAL ACCOMODATIONS	0.00	941.00
			TOTAL CHARGES	57,755,976.30	8,202,759.31

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

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,668,594.66	ADJUSTMENTS	0.00
COVERED CHARGES	931,326.76	CONTRACTUAL ALLOW	314,307.83
NON-COVERD CHARGES	737,267.90	TOTAL MEDICAID LIAB	617,018.93
		LESS: COB	616,566.37
		LESS: COPAYMENT	452.56
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 581

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

AU MEDICAL CENTER, INC
 1120 15TH ST
 AUGUSTA,GA 30912-0004

PROVIDER NUMBER
 000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	53,616.79	735.00	OTHER LAB	18,262.00	2,119.00
MED/SURG SUPPLY	45,590.00	20,839.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,988.00	290.00	OTHER THERAPEUTIC SVC	0.00	543.00
CT SCAN	13,750.00	23,711.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	361.00	FEE SCHEDULE LAB	155,215.11	10,081.37
EKG/ECG	9,135.00	316.00	MRI SERVICES	13,050.00	48,911.00
IV THERAPY	12,115.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	189,595.47	62,885.53	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	254.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,184.00	2,009.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	90,903.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	17,194.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	81,157.00	37.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	59,163.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,761.05	136,763.34
RADIOLOGY THERAPEUTIC	12,735.00	849.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	572.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,982.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	40,193.00	197.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	322.00	IMPL DEV CHARGE PATIENTS	3,285.00	320,802.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,310.00	18,002.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,130.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,206.00	4,017.00			
AUDIOLOGY	686.00	0.00			
CARDIOLOGY	26,758.34	62,431.66			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	36,377.00	1,298.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,907.00	0.00			
			TOTAL ANCILLARY	931,326.76	737,267.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	931,326.76	737,267.90

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: 08/24/2017
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AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,316,128.78	ADJUSTMENTS	3,793.58
COVERED CHARGES	2,204,752.62	CONTRACTUAL ALLOW	2,105,452.62
NON-COVERD CHARGES	111,376.16	TOTAL MEDICAID LIAB	99,300.00
		LESS: COB	48.58
		LESS: COPAYMENT	3,607.51
		REIMBURSEMENT	95,643.91
		TOTAL NUMBER OF CLAIMS	1,986

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

AU MEDICAL CENTER, INC
 1120 15TH ST
 AUGUSTA,GA 30912-0004

PROVIDER NUMBER
 000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	91,306.86	275.54	OTHER LAB	24,111.00	535.00
MED/SURG SUPPLY	19,491.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	103,493.00	499.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	233,837.00	62,378.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	722.00	FEE SCHEDULE LAB	319,574.00	7,194.00
EKG/ECG	17,064.00	158.00	MRI SERVICES	45,780.00	20,876.00
IV THERAPY	98,699.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	19,880.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,573.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,358.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,139,055.00	343.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,638.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,007.76	3,772.55
RADIOLOGY THERAPEUTIC	20,865.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	578.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,522.05	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	6,802.00	348.00	TRAUMA RESPONSE	0.00	4,179.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,966.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	28,355.00	6,127.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	995.00	1,869.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,902.00	0.00			
			TOTAL ANCILLARY	2,204,752.62	111,376.16
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,204,752.62	111,376.16

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

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

Run Date: 08/24/2017
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

AU MEDICAL CENTER, INC
 1120 15TH ST
 AUGUSTA,GA 30912-0004

PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
000000723A	SERVICE DATES	07/01/15	THROUGH	06/30/16
	ADMISSION DATES	00/00/00	THROUGH	00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,312.34	ADJUSTMENTS	0.00
COVERED CHARGES	17,270.34	CONTRACTUAL ALLOW	9,995.64
NON-COVERD CHARGES	42.00	TOTAL MEDICAID LIAB	7,274.70
		LESS: COB	7,256.70
		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: 08/24/2017
 Run Time: 03:38:02
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

AU MEDICAL CENTER, INC
 1120 15TH ST
 AUGUSTA,GA 30912-0004

PROVIDER NUMBER
 000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	284.34	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,523.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,660.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,004.00	42.00
EKG/ECG	158.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,198.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,443.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	17,270.34	42.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,270.34	42.00

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
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

Run Date: 08/24/2017
Run Time: 03:38:10
Page: 13

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----
TOTAL CHARGES 13,996,888.34
COVERED CHARGES 13,075,826.65
NON-COVERD CHARGES 921,061.69

-----PAYMENTS-----
ADJUSTMENTS 451,295.00
CONTRACTUAL ALLOW 11,722,024.42
TOTAL MEDICAID LIAB 1,353,802.23
LESS: COB 600.00
LESS: COPAYMENT 777.00

REIMBURSEMENT 1,352,425.23

TOTAL NUMBER OF CLAIMS 225

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

AU MEDICAL CENTER, INC
 1120 15TH ST
 AUGUSTA,GA 30912-0004

PROVIDER NUMBER
 000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	683,869.10	0.00	OTHER LAB	6,028.00	0.00
MED/SURG SUPPLY	1,301,578.00	545.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	109,456.00	2,127.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	32,977.00	15,961.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	722.00	7,157.00	FEE SCHEDULE LAB	245,021.00	11,540.00
EKG/ECG	5,688.00	0.00	MRI SERVICES	3,060.00	14,032.00
IV THERAPY	27,428.00	640.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,019,565.52	206,980.51	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	33,736.00	2,870.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	322,344.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	32,983.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	114,548.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,984,573.07	106,223.90
RADIOLOGY THERAPEUTIC	310,579.00	12,131.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	468.00	3,715.24	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	469.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	9,527.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,525.00	75.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,886,759.00	7,815.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	17,780.00	70.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,723.00	0.00			
ONCOLOGY	7,406.00	0.00			
NUCLEAR MEDICINE	10,070.00	7,623.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,845,037.96	510,994.04			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	28,987.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	36,915.00	566.00			
			TOTAL ANCILLARY	13,075,826.65	921,061.69
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,075,826.65	921,061.69

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: 08/24/2017
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/15	THROUGH	06/30/16
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: 08/24/2017
 Run Time: 02:57:01
 Page: 1

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	616,491.00	ADJUSTMENTS	0.00
COVERED CHARGES	580,946.00	CONTRACTUAL ALLOW	327,802.41
NON-COVERD CHARGES	35,545.00	TOTAL MEDICAID LIAB	253,143.59
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	253,143.59

TOTAL NUMBER OF ADMISSIONS 38

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	95		0	105,735.00		14,028.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	95		0	105,735.00		14,028.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	17		0	26,775.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	17		0	26,775.00		0.00
TOTAL ACCOMODATIONS	112		0	132,510.00		14,028.00

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

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

Run Date: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63,303.00	0.00	OTHER LAB	2,930.00	0.00
MED/SURG SUPPLY	44,904.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	152,549.00	0.00	EDUCATION & TRAINING	380.00	0.00
RADIOLOGY-DIAGNOSTIC	12,858.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	52,264.00	5,734.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	953.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,166.00	0.00	MRI SERVICES	3,692.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,238.00	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	47,736.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	30,061.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,281.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,216.00	3,293.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	11,606.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,299.00	9,655.00			
			TOTAL ANCILLARY	448,436.00	21,517.00
			TOTAL ACCOMODATIONS	132,510.00	14,028.00
			TOTAL CHARGES	580,946.00	35,545.00

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

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

Run Date: 08/24/2017
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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	10/01/15	THROUGH	09/30/16
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: 08/24/2017
Run Time: 02:57:02
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,546,170.31	ADJUSTMENTS	18,308.12
COVERED CHARGES	1,415,490.31	CONTRACTUAL ALLOW	1,126,774.62
NON-COVERD CHARGES	130,680.00	TOTAL MEDICAID LIAB	288,715.69
		LESS: COB	473.47
		LESS: COPAYMENT	933.00
		REIMBURSEMENT	287,309.22
		ALL OTHER	262,026.78
		FEE SCHEDULE-LAB	21,944.89
		INJECTABLE DRUGS	3,337.55

TOTAL NUMBER OF CLAIMS 975

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35,414.00	705.00	OTHER LAB	4,515.00	0.00
MED/SURG SUPPLY	44,914.00	190.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	206.00	EDUCATION & TRAINING	0.00	364.00
RADIOLOGY-DIAGNOSTIC	91,311.00	1,485.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	220,148.00	69,460.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	20,834.00	3,205.00	FEE SCHEDULE LAB	328,721.00	17,052.00
EKG/ECG	17,984.00	605.00	MRI SERVICES	69,255.00	3,692.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	43,372.00	9,066.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	37,365.00	776.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	41,203.00	2,500.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	355,696.00	5,982.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,012.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,862.00	2,457.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	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	3,267.31	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	292.00
OTHER IMAGING SERVICE	16,322.00	6,263.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,976.00	3,705.00			
ONCOLOGY	595.00	0.00			
NUCLEAR MEDICINE	1,934.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,755.00	394.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	57,035.00	2,139.00			
			TOTAL ANCILLARY	1,415,490.31	130,680.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,415,490.31	130,680.00

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: 08/24/2017
Run Time: 02:57:02
Page: 6

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
31	2216133001536	05/06/16 - 05/06/16	05/16/16	0.00	108.00	0.00	0.00	0.00
32	2216148014956	05/20/16 - 05/20/16	05/30/16	0.00	184.00	0.00	0.00	0.00
TOTAL				0.00	292.00	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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,920.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,075.00	CONTRACTUAL ALLOW	2,032.30
NON-COVERD CHARGES	845.00	TOTAL MEDICAID LIAB	1,042.70
		LESS: COB	1,042.70
		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

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 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	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,185.00	240.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,888.00	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	605.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,075.00	845.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,075.00	845.00

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: 08/24/2017
Run Time: 02:57:13
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	170,803.00	ADJUSTMENTS	52.94
COVERED CHARGES	160,024.00	CONTRACTUAL ALLOW	150,458.26
NON-COVERD CHARGES	10,779.00	TOTAL MEDICAID LIAB	9,565.74
		LESS: COB	0.00
		LESS: COPAYMENT	258.00
		REIMBURSEMENT	9,307.74
		TOTAL NUMBER OF CLAIMS	171

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,619.00	0.00	OTHER LAB	1,223.00	0.00
MED/SURG SUPPLY	1,477.00	51.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,123.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,260.00	4,675.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	26,261.00	4,228.00
EKG/ECG	416.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	476.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	104,838.00	486.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,321.00	21.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,010.00	1,318.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	160,024.00	10,779.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	160,024.00	10,779.00

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: 08/24/2017
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Page: 11

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,586.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,586.00	CONTRACTUAL ALLOW	1,754.57
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	831.43
		LESS: COB	825.43
		LESS: COPAYMENT	6.00
		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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	604.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	1,904.00	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	64.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,586.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,586.00	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

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	10/01/15	THROUGH	09/30/16
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: 08/24/2017
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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	10/01/15	THROUGH	09/30/16
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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	60,832,314.39	ADJUSTMENTS	5,052,027.99
COVERED CHARGES	58,733,867.70	CONTRACTUAL ALLOW	43,807,972.54
NON-COVERD CHARGES	2,098,446.69	TOTAL MEDICAID LIAB	14,925,895.16
		LESS: COB	92,122.45
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	14,833,772.71

TOTAL NUMBER OF ADMISSIONS 1,968

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	6,240		0	3,407,800.00		712,635.00
ROUTINE NURSERY	1,041		2	875,850.00		22,968.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	7,281		2	4,283,650.00		735,603.00
SPECIAL CARE SERVICES						
CCU	1,030		0	827,805.00		34,650.00
ICU	1,432		0	1,803,647.00		49,500.00
NICU	501		0	1,078,152.00		0.00
PED ICU	20		0	24,200.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,983		0	3,733,804.00		84,150.00
TOTAL ACCOMODATIONS	10,264		2	8,017,454.00		819,753.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,380,772.15	75,480.50	OTHER LAB	295,446.00	0.00
MED/SURG SUPPLY	4,638,977.56	108,813.59	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,975,119.00	112,407.00	EDUCATION & TRAINING	12,444.00	108.00
RADIOLOGY-DIAGNOSTIC	779,865.00	4,138.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,583,850.00	24,450.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	80,536.00	836.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	994,646.00	10,512.00	MRI SERVICES	445,148.00	1,548.00
IV THERAPY	385,724.00	11,712.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,529,024.33	55,156.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,153,134.00	1,200.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,756,750.00	106,896.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	779,314.00	4,995.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,149,255.00	14,193.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	551,649.00	3,420.00	DRUG-SPECIFIC/HOME IV	0.00	106,610.00
LABORATORY PATHOLOGIC	222,554.00	2,861.00	INJECTABLE DRUGS	2,760,921.67	177,369.10
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	38,662.00	228.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	34,068.00	1,389.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	237,812.00	51,097.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	11,828.00	18,886.00	TRAUMA RESPONSE	0.00	62,520.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,445,037.99	4,655.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	162,884.00	84,538.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	283,928.00	155,452.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	227,071.00	68,198.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,583,747.00	700.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	22,260.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	193,986.00	8,325.00			
			TOTAL ANCILLARY	50,716,413.70	1,278,693.69
			TOTAL ACCOMODATIONS	8,017,454.00	819,753.00
			TOTAL CHARGES	58,733,867.70	2,098,446.69

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

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

Run Date: 08/24/2017
 Run Time: 02:59:40
 Page: 3

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	674,549.34	ADJUSTMENTS	0.00
COVERED CHARGES	664,970.34	CONTRACTUAL ALLOW	356,697.01
NON-COVERD CHARGES	9,579.00	TOTAL MEDICAID LIAB	308,273.33
		LESS: COB	308,273.33
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 27

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	107		0	58,850.00		6,765.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	107		0	58,850.00		6,765.00
SPECIAL CARE SERVICES						
CCU	15		0	12,375.00		0.00
ICU	6		0	9,900.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	22,275.00		0.00
TOTAL ACCOMODATIONS	128		0	81,125.00		6,765.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	107,076.00	0.00	OTHER LAB	20,159.00	0.00
MED/SURG SUPPLY	65,038.59	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	77,481.00	0.00	EDUCATION & TRAINING	72.00	0.00
RADIOLOGY-DIAGNOSTIC	5,414.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,440.00	390.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	304.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,896.00	0.00	MRI SERVICES	1,530.00	0.00
IV THERAPY	30,952.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	56,533.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	87,304.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,116.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	24,351.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,708.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,640.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,830.00	0.00	INJECTABLE DRUGS	12,117.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	82.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	196.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	10,157.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,579.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,433.00	2,424.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,200.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,236.00	0.00			
			TOTAL ANCILLARY	583,845.34	2,814.00
			TOTAL ACCOMODATIONS	81,125.00	6,765.00
			TOTAL CHARGES	664,970.34	9,579.00

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: 08/24/2017
Run Time: 02:59:43
Page: 5

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	45,757,330.20	ADJUSTMENTS	1,673,899.52
COVERED CHARGES	43,290,699.05	CONTRACTUAL ALLOW	36,697,537.36
NON-COVERD CHARGES	2,466,631.15	TOTAL MEDICAID LIAB	6,593,161.69
		LESS: COB	8,462.31
		LESS: COPAYMENT	15,087.13
		REIMBURSEMENT	6,569,612.25
		ALL OTHER	5,977,970.60
		FEE SCHEDULE-LAB	536,837.92
		INJECTABLE DRUGS	54,803.73

TOTAL NUMBER OF CLAIMS 14,165

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,880,847.35	1,576.50	OTHER LAB	179,077.00	3,776.00
MED/SURG SUPPLY	2,234,649.00	37,128.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	9,194.00	EDUCATION & TRAINING	10,345.00	2,200.00
RADIOLOGY-DIAGNOSTIC	1,220,677.00	22,237.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,079,513.00	131,699.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	157,704.00	23,849.00	FEE SCHEDULE LAB	7,859,901.82	420,996.00
EKG/ECG	680,339.00	8,852.00	MRI SERVICES	647,979.00	68,374.00
IV THERAPY	2,839,453.00	234,902.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,530,613.60	530,255.40	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	187,505.00	680.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	396,042.00	187,255.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	609,883.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,599,186.03	327,384.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	636,896.00	0.00	DRUG-SPECIFIC/HOME IV	280.00	13,650.00
LABORATORY PATHOLOGIC	0.00	420.00	INJECTABLE DRUGS	372,304.00	39,371.25
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	234.00	884.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	2,128.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	44,192.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	419,551.00	13,857.00	TRAUMA RESPONSE	0.00	19,008.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	275,667.25	0.00
LITHOTRIPSY	70,360.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	410,142.00	34,757.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	41,771.00	18,554.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	561,730.00	81,213.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	859,550.00	153,804.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	149,656.00	1,408.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,378,843.00	33,027.00			
			TOTAL ANCILLARY	43,290,699.05	2,466,631.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	43,290,699.05	2,466,631.15

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,072,092.50	ADJUSTMENTS	0.00
COVERED CHARGES	882,406.25	CONTRACTUAL ALLOW	437,685.10
NON-COVERD CHARGES	189,686.25	TOTAL MEDICAID LIAB	444,721.15
		LESS: COB	444,583.27
		LESS: COPAYMENT	137.88
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 222

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	50,245.50	49.25	OTHER LAB	8,711.00	410.00
MED/SURG SUPPLY	65,900.00	1,223.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	527.00	0.00
RADIOLOGY-DIAGNOSTIC	22,667.00	1,165.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,666.00	46,704.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	145,784.00	10,535.00
EKG/ECG	6,262.00	544.00	MRI SERVICES	14,921.00	0.00
IV THERAPY	37,344.00	154.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	167,837.00	91,731.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	26,181.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,079.00	3,122.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	31,230.00	2,080.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	172,888.00	2,982.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	36,171.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,386.75	285.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	82.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	304.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	9,315.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	34,018.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,790.00	6,721.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,394.00	606.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,964.00	17,214.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,196.00	2,950.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,204.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,725.00	825.00			
			TOTAL ANCILLARY	882,406.25	189,686.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	882,406.25	189,686.25

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	956,392.25	ADJUSTMENTS	1,023.86
COVERED CHARGES	936,425.25	CONTRACTUAL ALLOW	902,861.25
NON-COVERD CHARGES	19,967.00	TOTAL MEDICAID LIAB	33,564.00
		LESS: COB	50.00
		LESS: COPAYMENT	1,182.00
		REIMBURSEMENT	32,332.00
		TOTAL NUMBER OF CLAIMS	600

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	40,707.75	0.00	OTHER LAB	479.00	0.00
MED/SURG SUPPLY	17,463.00	49.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	504.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	51,497.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,530.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	103,006.00	3,526.00
EKG/ECG	1,932.00	0.00	MRI SERVICES	6,885.00	0.00
IV THERAPY	5,748.00	154.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	450.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	693,305.00	9,926.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	980.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,170.50	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	4,143.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,327.00	620.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,925.00	0.00			
			TOTAL ANCILLARY	936,425.25	19,967.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	936,425.25	19,967.00

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

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	39,712.75	ADJUSTMENTS	0.00
COVERED CHARGES	33,994.75	CONTRACTUAL ALLOW	17,634.45
NON-COVERD CHARGES	5,718.00	TOTAL MEDICAID LIAB	16,360.30
		LESS: COB	16,330.30
		LESS: COPAYMENT	30.00
		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

Run Date: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	694.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	812.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,267.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	4,900.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,649.00	818.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	706.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,729.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,377.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	760.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	33,994.75	5,718.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	33,994.75	5,718.00

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

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,496,128.25	ADJUSTMENTS	218,349.89
COVERED CHARGES	4,359,454.25	CONTRACTUAL ALLOW	3,815,548.19
NON-COVERD CHARGES	136,674.00	TOTAL MEDICAID LIAB	543,906.06
		LESS: COB	0.00
		LESS: COPAYMENT	285.00
		REIMBURSEMENT	543,621.06

TOTAL NUMBER OF CLAIMS 95

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	716,163.50	0.00	OTHER LAB	5,998.00	0.00
MED/SURG SUPPLY	332,964.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	252.00	180.00
RADIOLOGY-DIAGNOSTIC	17,761.00	1,940.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	70,363.00	4,766.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	380.00	FEE SCHEDULE LAB	180,104.00	9,747.00
EKG/ECG	33,172.00	0.00	MRI SERVICES	8,088.00	4,644.00
IV THERAPY	376,702.00	27,874.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,434,195.00	10,970.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	30,801.00	7,104.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	152,220.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	80,185.00	550.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	110,926.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,400.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	24,855.75	840.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	234.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,762.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	544.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	558,915.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,508.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	11,561.00	1,616.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	89,911.00	55,997.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	120,264.00	5,670.00			
			TOTAL ANCILLARY	4,359,454.25	136,674.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,359,454.25	136,674.00

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: 08/24/2017
Run Time: 03:01:17
Page: 15

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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
 Run Time: 03:57:04
 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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	46,320,285.43	ADJUSTMENTS	2,644,313.18
COVERED CHARGES	44,041,757.93	CONTRACTUAL ALLOW	35,114,915.25
NON-COVERD CHARGES	2,278,527.50	TOTAL MEDICAID LIAB	8,926,842.68
		LESS: COB	90,017.88
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,836,824.80

TOTAL NUMBER OF ADMISSIONS 1,166

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,989		0	4,375,588.00		758,029.00
ROUTINE NURSERY	1,571		0	2,371,135.00		608,522.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5,560		0	6,746,723.00		1,366,551.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	548		0	2,133,745.00		0.00
NICU	128		0	744,192.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	676		0	2,877,937.00		0.00
TOTAL ACCOMODATIONS	6,236		0	9,624,660.00		1,366,551.00

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,695,294.04	111,091.50	OTHER LAB	92,383.00	1,266.00
MED/SURG SUPPLY	2,069,074.50	37,232.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,231,526.10	83,172.00	EDUCATION & TRAINING	2,161.00	75.00
RADIOLOGY-DIAGNOSTIC	583,707.00	3,711.00	OTHER THERAPEUTIC SVC	0.00	47,701.00
CT SCAN	1,275,121.00	11,663.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	333,096.00	4,103.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	159,384.00	333.00	MRI SERVICES	494,405.00	4,786.00
IV THERAPY	54,526.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,974,052.00	78,033.00	DURABLE MED. EQUIP.	0.00	1,990.00
LABOR/DELIVERY ROOM	1,241,049.00	0.00	REHAB THERAPY	258.00	0.00
RESPIRATORY SERVICES	2,414,969.00	12,672.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	404,750.00	15,244.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	882,270.00	2,802.00	SPECIAL SERVICES	0.00	86,626.00
RECOVERY ROOM	362,394.00	2,534.00	DRUG-SPECIFIC/HOME IV	0.00	26,834.00
LABORATORY PATHOLOGIC	269,245.00	9,672.00	INJECTABLE DRUGS	8,285,153.00	168,349.00
RADIOLOGY THERAPEUTIC	301,156.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	162,569.00	1,374.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	93,432.00	726.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	146,979.00	39,475.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	190.00	106.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,596.00	0.00	IMPL DEV CHARGE PATIENTS	902,737.29	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	282,292.00	74,290.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	442,472.00	55,402.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	132,414.00	29,687.00			
AUDIOLOGY	130,698.00	0.00			
CARDIOLOGY	951,749.00	1,027.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	13,500.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	30,496.00	0.00			
			TOTAL ANCILLARY	34,417,097.93	911,976.50
			TOTAL ACCOMODATIONS	9,624,660.00	1,366,551.00
			TOTAL CHARGES	44,041,757.93	2,278,527.50

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	682,823.50	ADJUSTMENTS	0.00
COVERED CHARGES	665,249.50	CONTRACTUAL ALLOW	394,330.50
NON-COVERD CHARGES	17,574.00	TOTAL MEDICAID LIAB	270,919.00
		LESS: COB	270,919.00
		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	63		0	69,362.00		6,860.00
ROUTINE NURSERY	33		0	83,820.00		6,015.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	96		0	153,182.00		12,875.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	16		0	93,024.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	93,024.00		0.00
TOTAL ACCOMODATIONS	112		0	246,206.00		12,875.00

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	54,868.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	27,133.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	54,576.00	0.00	EDUCATION & TRAINING	75.00	0.00
RADIOLOGY-DIAGNOSTIC	6,224.00	0.00	OTHER THERAPEUTIC SVC	0.00	805.00
CT SCAN	2,623.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,572.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,996.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	322.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	42,086.00	0.00	DURABLE MED. EQUIP.	0.00	117.00
LABOR/DELIVERY ROOM	52,961.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	33,903.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,742.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,328.00	0.00	SPECIAL SERVICES	0.00	3,777.00
RECOVERY ROOM	6,219.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,018.00	0.00	INJECTABLE DRUGS	57,672.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,660.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	47,897.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,199.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	1,367.00	0.00			
CARDIOLOGY	2,602.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	419,043.50	4,699.00
			TOTAL ACCOMODATIONS	246,206.00	12,875.00
			TOTAL CHARGES	665,249.50	17,574.00

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: 08/24/2017
Run Time: 03:57:13
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,053,996.81	ADJUSTMENTS	512,179.08
COVERED CHARGES	13,830,411.81	CONTRACTUAL ALLOW	11,815,703.20
NON-COVERD CHARGES	1,223,585.00	TOTAL MEDICAID LIAB	2,014,708.61
		LESS: COB	3,889.73
		LESS: COPAYMENT	6,094.69
		REIMBURSEMENT	2,004,724.19
		ALL OTHER	1,746,840.09
		FEE SCHEDULE-LAB	100,802.16
		INJECTABLE DRUGS	157,081.94

TOTAL NUMBER OF CLAIMS 3,641

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	346,474.00	5,593.00	OTHER LAB	186,162.00	0.00
MED/SURG SUPPLY	538,805.50	5,106.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	5,521.00	EDUCATION & TRAINING	1,032.00	0.00
RADIOLOGY-DIAGNOSTIC	489,601.00	12,648.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,498,509.00	225,876.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	106,160.00	23,867.00	FEE SCHEDULE LAB	1,662,987.66	82,642.40
EKG/ECG	97,913.00	4,013.00	MRI SERVICES	1,146,986.00	96,178.00
IV THERAPY	354,855.00	6,050.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,161,435.00	107,888.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	32,265.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	33,099.00	2,894.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	217,194.00	3,786.00	AMBULANCE	0.00	0.00
GI SERVICES	3,615.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,486,785.00	30,202.00	SPECIAL SERVICES	0.00	468.00
RECOVERY ROOM	213,470.00	569.00	DRUG-SPECIFIC/HOME IV	0.00	2,667.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,511,247.00	352,819.60
RADIOLOGY THERAPEUTIC	538,573.00	85,460.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	10,557.00	8,343.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,452.00	1,452.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	9,446.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,341.00	762.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,363.00	798.00	IMPL DEV CHARGE PATIENTS	113,431.25	391.00
LITHOTRIPSY	21,181.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	579,765.00	114,955.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	154,209.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	70,350.00	16,421.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	128,176.00	16,639.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,936.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	112,482.40	130.00			
			TOTAL ANCILLARY	13,830,411.81	1,223,585.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,830,411.81	1,223,585.00

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

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

Run Date: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	525,062.20	ADJUSTMENTS	0.00
COVERED CHARGES	366,031.80	CONTRACTUAL ALLOW	201,893.68
NON-COVERD CHARGES	159,030.40	TOTAL MEDICAID LIAB	164,138.12
		LESS: COB	163,907.17
		LESS: COPAYMENT	230.95
		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

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,344.00	0.00	OTHER LAB	4,287.00	0.00
MED/SURG SUPPLY	11,081.00	133.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	657.60	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,759.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,839.00	29,303.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,092.00	1,665.00	FEE SCHEDULE LAB	66,637.80	3,393.80
EKG/ECG	2,664.00	333.00	MRI SERVICES	25,140.00	14,358.00
IV THERAPY	15,624.00	885.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,766.00	14,485.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,417.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	448.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,495.00	631.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	103,743.00	6,587.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,610.00	1,053.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,264.00	42,664.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	3,520.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,240.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,789.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	19,639.00	27,800.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	10,322.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	627.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,766.00	0.00			
			TOTAL ANCILLARY	366,031.80	159,030.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	366,031.80	159,030.40

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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	557,240.74	ADJUSTMENTS	1,017.86
COVERED CHARGES	532,407.24	CONTRACTUAL ALLOW	518,590.06
NON-COVERD CHARGES	24,833.50	TOTAL MEDICAID LIAB	13,817.18
		LESS: COB	0.00
		LESS: COPAYMENT	391.87
		REIMBURSEMENT	13,425.31
		TOTAL NUMBER OF CLAIMS	247

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,352.00	0.00	OTHER LAB	802.00	0.00
MED/SURG SUPPLY	24,791.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,925.00	389.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	63,593.00	5,040.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	88,655.00	2,880.00
EKG/ECG	4,995.00	0.00	MRI SERVICES	3,892.00	7,784.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,765.00	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	4,214.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	254,171.00	818.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,864.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	27,736.00	4,379.50
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	10,250.00	3,543.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,217.24	0.00			
			TOTAL ANCILLARY	532,407.24	24,833.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	532,407.24	24,833.50

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

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,373.00	ADJUSTMENTS	0.00
COVERED CHARGES	14,255.00	CONTRACTUAL ALLOW	8,614.85
NON-COVERD CHARGES	1,118.00	TOTAL MEDICAID LIAB	5,640.15
		LESS: COB	5,634.15
		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

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	78.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	375.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	494.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,452.00	54.00
EKG/ECG	333.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,523.00	27.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	183.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	854.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	14,255.00	1,118.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,255.00	1,118.00

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

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,365,681.70	ADJUSTMENTS	36,001.02
COVERED CHARGES	1,328,188.70	CONTRACTUAL ALLOW	1,190,058.64
NON-COVERD CHARGES	37,493.00	TOTAL MEDICAID LIAB	138,130.06
		LESS: COB	0.00
		LESS: COPAYMENT	120.00
		REIMBURSEMENT	138,010.06

TOTAL NUMBER OF CLAIMS 23

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,873.00	0.00	OTHER LAB	240.00	117.00
MED/SURG SUPPLY	55,360.00	938.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,511.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,809.00	3,809.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	19,096.00	579.00
EKG/ECG	2,331.00	0.00	MRI SERVICES	0.00	4,410.00
IV THERAPY	36,605.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	272,519.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,405.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	29,793.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,863.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,589.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	318,399.50	24,175.00
RADIOLOGY THERAPEUTIC	90,777.00	3,465.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	391,100.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,210.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,781.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	39,118.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,809.20	0.00			
			TOTAL ANCILLARY	1,328,188.70	37,493.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,328,188.70	37,493.00

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

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	10/01/15	THROUGH	09/30/16
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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,818,364.07	ADJUSTMENTS	2,178,653.43
COVERED CHARGES	5,673,657.07	CONTRACTUAL ALLOW	2,586,843.03
NON-COVERD CHARGES	144,707.00	TOTAL MEDICAID LIAB	3,086,814.04
		LESS: COB	20,011.93
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,066,802.11

TOTAL NUMBER OF ADMISSIONS 119

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,917		0	2,519,100.00		68,850.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,917		0	2,519,100.00		68,850.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	1,917		0	2,519,100.00		68,850.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	460,952.05	10,028.00	OTHER LAB	2,206.00	0.00
MED/SURG SUPPLY	140,624.50	11,630.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	196,772.00	17,137.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	23,357.50	446.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,400.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	868,908.88	14,989.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	7,972.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,839.50	0.00	PROFESSIONAL FEES	0.00	200.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	96,705.50	1,895.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,771.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,766.00	0.00	INJECTABLE DRUGS	441.35	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	918,077.80	15,848.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	377,239.24	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	26,040.00	1,240.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,881.00	0.00			
BLOOD	3,140.00	0.00			
BLOOD STORAGE & PRO.	0.00	2,444.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	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	200.00	0.00			
			TOTAL ANCILLARY	3,154,557.07	75,857.00
			TOTAL ACCOMODATIONS	2,519,100.00	68,850.00
			TOTAL CHARGES	5,673,657.07	144,707.00

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

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	07/01/15	THROUGH	06/30/16
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 07/01/15 THROUGH 06/30/16
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 07/01/15 THROUGH 06/30/16
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: 08/24/2017
Run Time: 04:02:49
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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	07/01/15	THROUGH	06/30/16
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

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	07/01/15	THROUGH	06/30/16
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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
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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	07/01/15	THROUGH	06/30/16
WARM SPRINGS,GA 31830-2757		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: 08/24/2017
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

WELLSTAR ATLANTA MEDICAL CENTER, INC
 303 PARKWAY DRIVE, NE
 ATLANTA,GA 30312-1212

PROVIDER NUMBER 000000789A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	63,998,912.33	ADJUSTMENTS	2,352,992.91
COVERED CHARGES	62,232,688.91	CONTRACTUAL ALLOW	53,017,667.31
NON-COVERD CHARGES	1,766,223.42	TOTAL MEDICAID LIAB	9,215,021.60
		LESS: COB	47,943.26
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,167,078.34

TOTAL NUMBER OF ADMISSIONS 976

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,119		0	4,841,726.00		258,868.00
ROUTINE NURSERY	283		0	374,268.00		1,072.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,402		0	5,215,994.00		259,940.00
SPECIAL CARE SERVICES						
CCU	4		0	16,932.00		0.00
ICU	2,582		0	8,322,814.00		56,764.00
NICU	6		0	23,148.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,592		0	8,362,894.00		56,764.00
TOTAL ACCOMODATIONS	5,994		0	13,578,888.00		316,704.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

WELLSTAR ATLANTA MEDICAL CENTER, INC
 303 PARKWAY DRIVE, NE
 ATLANTA, GA 30312-1212

PROVIDER NUMBER
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,299,513.62	101,703.82	OTHER LAB	151,696.76	0.00
MED/SURG SUPPLY	3,637,706.00	86,427.08	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,153,702.56	36,710.58	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,129,984.38	3,828.85	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,530,009.79	144,687.61	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	319,006.68	3,300.73	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	202,720.56	1,134.63	MRI SERVICES	676,313.29	13,137.36
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,828,108.40	2,134.68	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	644,382.53	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,845,430.08	20,367.78	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,279,302.12	0.00	AMBULANCE	0.00	0.00
GI SERVICES	105,695.01	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,550,356.50	9,566.55	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	655,352.95	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	144,940.20	0.00	INJECTABLE DRUGS	1,451.66	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	222,689.87	1,697.51	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	205,731.61	528.39	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	330,004.68	6,674.34	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	15,270.64	117.92	TRAUMA RESPONSE	0.00	542,774.98
PSYCHIATRIC SERVICES	276,795.53	0.00	IMPL DEV CHARGE PATIENTS	1,675,690.78	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	237,582.90	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	473,118.09			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	603,534.80	0.00			
AUDIOLOGY	21,698.69	0.00			
CARDIOLOGY	846,032.58	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	50,451.46	1,608.52			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,644.28	0.00			
			TOTAL ANCILLARY	48,653,800.91	1,449,519.42
			TOTAL ACCOMODATIONS	13,578,888.00	316,704.00
			TOTAL CHARGES	62,232,688.91	1,766,223.42

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

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 03/31/16
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: 08/24/2017
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WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,855,909.19	ADJUSTMENTS	127,628.99
COVERED CHARGES	15,756,412.99	CONTRACTUAL ALLOW	14,532,974.82
NON-COVERD CHARGES	1,099,496.20	TOTAL MEDICAID LIAB	1,223,438.17
		LESS: COB	0.00
		LESS: COPAYMENT	2,007.00
		REIMBURSEMENT	1,221,431.17
		ALL OTHER	1,122,634.66
		FEE SCHEDULE-LAB	84,930.67
		INJECTABLE DRUGS	13,865.84
		TOTAL NUMBER OF CLAIMS	3,870

WELLSTAR ATLANTA MEDICAL CENTER, INC
 303 PARKWAY DRIVE, NE
 ATLANTA, GA 30312-1212

PROVIDER NUMBER
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	809,187.40	2,466.89	OTHER LAB	73,233.26	0.00
MED/SURG SUPPLY	816,026.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	25,477.20	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,027,105.77	14,362.12	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,283,590.27	158,195.43	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,599.63	FEE SCHEDULE LAB	1,772,177.60	86,993.23
EKG/ECG	205,204.82	1,891.05	MRI SERVICES	253,377.37	20,914.09
IV THERAPY	814,159.31	4,752.13	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,098,052.58	207,766.49	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	40,281.71	6,038.11	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	614,224.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	58,596.67	4,523.53	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,805,716.74	17,113.57	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	164,179.58	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	743,408.18	166,893.23
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	457.19	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	7,786.73	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	18,750.98	3,843.43	TRAUMA RESPONSE	0.00	138,837.65
PSYCHIATRIC SERVICES	100,565.85	0.00	IMPL DEV CHARGE PATIENTS	85,261.97	0.00
LITHOTRIpsy	66,919.26	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	457,243.40	108,397.88			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	14,457.72			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	157,224.48	40,096.20			
AUDIOLOGY	2,577.40	438.28			
CARDIOLOGY	94,656.86	53,213.47			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	99,892.80	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	94,797.68	11,980.95			
			TOTAL ANCILLARY	15,756,412.99	1,099,496.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,756,412.99	1,099,496.20

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 ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,430.20	ADJUSTMENTS	0.00
COVERED CHARGES	9,065.30	CONTRACTUAL ALLOW	3,904.49
NON-COVERD CHARGES	1,364.90	TOTAL MEDICAID LIAB	5,160.81
		LESS: COB	5,159.58
		LESS: COPAYMENT	1.23
		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

WELLSTAR ATLANTA MEDICAL CENTER, INC
 303 PARKWAY DRIVE, NE
 ATLANTA,GA 30312-1212

PROVIDER NUMBER
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	78.76	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	15.57	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,039.09	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,596.36	0.00
EKG/ECG	378.21	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,145.76	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	180.78	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	1,630.77	1,364.90			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,065.30	1,364.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,065.30	1,364.90

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

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WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,344,585.61	ADJUSTMENTS	485.46
COVERED CHARGES	1,283,583.81	CONTRACTUAL ALLOW	1,248,956.95
NON-COVERD CHARGES	61,001.80	TOTAL MEDICAID LIAB	34,626.86
		LESS: COB	37.94
		LESS: COPAYMENT	1,170.23
		REIMBURSEMENT	33,418.69
		TOTAL NUMBER OF CLAIMS	619

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR ATLANTA MEDICAL CENTER, INC
 303 PARKWAY DRIVE, NE
 ATLANTA,GA 30312-1212

PROVIDER NUMBER
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	58,611.86	10.51	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	15,758.11	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	3,033.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	66,428.81	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	128,584.74	18,321.10	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	190,118.83	4,819.20
EKG/ECG	7,185.99	0.00	MRI SERVICES	9,504.28	9,591.04
IV THERAPY	90,482.23	1,754.23	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	144.61	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	615,957.03	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	63,083.55	5,320.65
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	4,788.85	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	32,934.92	18,152.07			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,283,583.81	61,001.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,283,583.81	61,001.80

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

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

Run Date: 08/24/2017
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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/16	THROUGH	03/31/16
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: 08/24/2017
Run Time: 02:05:02
Page: 11

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

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	401,792.95	ADJUSTMENTS	0.00
COVERED CHARGES	400,014.14	CONTRACTUAL ALLOW	381,798.51
NON-COVERD CHARGES	1,778.81	TOTAL MEDICAID LIAB	18,215.63
		LESS: COB	0.00
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	18,197.63

TOTAL NUMBER OF CLAIMS 3

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

WELLSTAR ATLANTA MEDICAL CENTER, INC
 303 PARKWAY DRIVE, NE
 ATLANTA,GA 30312-1212

PROVIDER NUMBER
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,859.78	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	50,648.24	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	622.94	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,560.86	0.00
EKG/ECG	378.21	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	125,819.39	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	22,806.14	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,428.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,409.72	1,778.81
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	157,399.18	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,054.63	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,026.65	0.00			
			TOTAL ANCILLARY	400,014.14	1,778.81
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	400,014.14	1,778.81

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: 08/24/2017
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/16	THROUGH	03/31/16
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: 08/24/2017
 Run Time: 02:05:13
 Page: 1

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

WELLSTAR ATLANTA MEDICAL CENTER, INC
 303 PARKWAY DRIVE, NE
 ATLANTA,GA 30312-1212

PROVIDER NUMBER 000000789A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	69,405,847.97	ADJUSTMENTS	3,497,847.09
COVERED CHARGES	66,077,187.44	CONTRACTUAL ALLOW	55,844,897.85
NON-COVERD CHARGES	3,328,660.53	TOTAL MEDICAID LIAB	10,232,289.59
		LESS: COB	50,092.56
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	10,182,197.03

TOTAL NUMBER OF ADMISSIONS 931

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,029		0	4,634,740.00		333,007.00
ROUTINE NURSERY	322		0	470,400.00		1,007.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,351		0	5,105,140.00		334,014.00
SPECIAL CARE SERVICES						
CCU	31		0	134,562.00		0.00
ICU	2,875		0	9,734,549.00		144,793.00
NICU	8		0	30,864.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		11	0.00		29,612.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,914		11	9,899,975.00		174,405.00
TOTAL ACCOMODATIONS	6,265		11	15,005,115.00		508,419.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

WELLSTAR ATLANTA MEDICAL CENTER, INC
 303 PARKWAY DRIVE, NE
 ATLANTA, GA 30312-1212

PROVIDER NUMBER
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,209,803.73	780,982.10	OTHER LAB	161,125.24	0.00
MED/SURG SUPPLY	3,550,492.58	192,395.54	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,239,988.86	143,573.09	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,054,990.15	11,056.02	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,947,437.86	118,463.93	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	375,413.93	12,555.53	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	187,076.80	770.60	MRI SERVICES	732,811.57	0.00
IV THERAPY	2,636.40	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,376,160.10	21,730.82	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	498,641.51	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,543,026.38	148,883.56	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,220,492.39	0.00	AMBULANCE	0.00	0.00
GI SERVICES	89,336.18	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,607,634.16	21,317.15	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	639,203.71	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	201,344.52	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	172,748.91	2,923.33	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	167,811.20	1,802.74	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	349,062.41	54,507.11	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,734.81	58.96	TRAUMA RESPONSE	0.00	476,053.71
PSYCHIATRIC SERVICES	235,683.26	0.00	IMPL DEV CHARGE PATIENTS	1,693,396.97	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	233,200.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	833,167.34			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	518,146.69	0.00			
AUDIOLOGY	18,832.90	0.00			
CARDIOLOGY	922,792.09	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	94,029.73	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	21,017.40	0.00			
			TOTAL ANCILLARY	51,072,072.44	2,820,241.53
			TOTAL ACCOMODATIONS	15,005,115.00	508,419.00
			TOTAL CHARGES	66,077,187.44	3,328,660.53

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: 08/24/2017
 Run Time: 02:05:35
 Page: 3

WELLSTAR ATLANTA MEDICAL CENTER, INC
 303 PARKWAY DRIVE, NE
 ATLANTA,GA 30312-1212

PROVIDER NUMBER 000000789A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,667,468.56	ADJUSTMENTS	0.00
COVERED CHARGES	28,836.86	CONTRACTUAL ALLOW	25,338.54
NON-COVERD CHARGES	1,638,631.70	TOTAL MEDICAID LIAB	3,498.32
		LESS: COB	3,498.32
		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	157		0	4,668.00		258,702.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	157		0	4,668.00		258,702.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	2		0	0.00		8,625.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	0.00		8,625.00
TOTAL ACCOMODATIONS	159		0	4,668.00		267,327.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR ATLANTA MEDICAL CENTER, INC
 303 PARKWAY DRIVE, NE
 ATLANTA, GA 30312-1212

PROVIDER NUMBER
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,558.60	464,535.32	OTHER LAB	0.00	8,605.12
MED/SURG SUPPLY	2,223.32	76,819.97	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,465.10	96,690.99	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	27,753.61	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	90,266.98	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	13,374.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	1,162.99	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	312,731.12	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,099.46	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	120,998.46	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,133.65	19,825.01	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	2,732.04	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,688.73	5,217.68	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	19,431.37	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	26,396.90	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	71,075.62
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,266.06			
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	9,083.78			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	3,337.68			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	24,168.86	1,371,304.70
			TOTAL ACCOMODATIONS	4,668.00	267,327.00
			TOTAL CHARGES	28,836.86	1,638,631.70

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: 08/24/2017
Run Time: 02:05:35
Page: 5

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/16 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,937,577.19	ADJUSTMENTS	140,084.87
COVERED CHARGES	16,858,124.89	CONTRACTUAL ALLOW	15,564,389.94
NON-COVERD CHARGES	1,079,452.30	TOTAL MEDICAID LIAB	1,293,734.95
		LESS: COB	129.82
		LESS: COPAYMENT	2,094.42
		REIMBURSEMENT	1,291,510.71
		ALL OTHER	1,169,977.82
		FEE SCHEDULE-LAB	105,514.32
		INJECTABLE DRUGS	16,018.57
		TOTAL NUMBER OF CLAIMS	3,839

WELLSTAR ATLANTA MEDICAL CENTER, INC
 303 PARKWAY DRIVE, NE
 ATLANTA,GA 30312-1212

PROVIDER NUMBER
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	834,239.68	3,379.39	OTHER LAB	60,992.53	0.00
MED/SURG SUPPLY	781,539.46	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,061,269.66	4,858.94	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,479,529.11	208,961.63	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,870.00	2,144.67	FEE SCHEDULE LAB	2,131,972.60	16,620.17
EKG/ECG	222,765.69	756.42	MRI SERVICES	254,198.11	56,790.94
IV THERAPY	841,369.69	825.38	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,146,394.40	103,340.51	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	42,439.43	13,367.74	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	570,525.27	0.00	AMBULANCE	0.00	0.00
GI SERVICES	56,173.91	15,859.92	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,819,803.58	2,668.26	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	152,930.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	2,570.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	781,142.51	169,104.88
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,504.10	1,421.62	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	33,371.70	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	19,328.12	4,915.08	TRAUMA RESPONSE	0.00	256,055.95
PSYCHIATRIC SERVICES	151,363.58	0.00	IMPL DEV CHARGE PATIENTS	88,856.85	0.00
LITHOTRIPSY	133,838.52	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	521,511.86	104,087.82			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	19,826.14			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	178,818.23	0.00			
AUDIOLOGY	2,433.88	476.10			
CARDIOLOGY	88,438.57	44,992.91			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	297,445.96	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	128,429.59	13,056.13			
			TOTAL ANCILLARY	16,858,124.89	1,079,452.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,858,124.89	1,079,452.30

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

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

Run Date: 08/24/2017
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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/16 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,074.99	ADJUSTMENTS	0.00
COVERED CHARGES	9,056.05	CONTRACTUAL ALLOW	6,163.27
NON-COVERD CHARGES	18.94	TOTAL MEDICAID LIAB	2,892.78
		LESS: COB	2,891.91
		LESS: COPAYMENT	0.87
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

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

WELLSTAR ATLANTA MEDICAL CENTER, INC
 303 PARKWAY DRIVE, NE
 ATLANTA,GA 30312-1212

PROVIDER NUMBER
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,204.72	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,676.41	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	1,912.66	18.94
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	2,873.30	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	378.21	0.00			
			TOTAL ANCILLARY	9,056.05	18.94
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,056.05	18.94

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: 08/24/2017
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WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/16 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,389,756.76	ADJUSTMENTS	323.64
COVERED CHARGES	1,350,871.67	CONTRACTUAL ALLOW	1,317,083.91
NON-COVERD CHARGES	38,885.09	TOTAL MEDICAID LIAB	33,787.76
		LESS: COB	0.00
		LESS: COPAYMENT	1,295.81
		REIMBURSEMENT	32,491.95
		TOTAL NUMBER OF CLAIMS	604

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

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

Run Date: 08/24/2017
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SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR ATLANTA MEDICAL CENTER, INC
 303 PARKWAY DRIVE, NE
 ATLANTA, GA 30312-1212

PROVIDER NUMBER
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55,542.78	0.00	OTHER LAB	1,657.46	0.00
MED/SURG SUPPLY	24,871.05	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	73,419.35	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	133,495.93	8,078.18	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	222,311.38	2,210.30
EKG/ECG	9,077.04	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	82,952.52	211.35	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,664.02	1,827.65	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	867.66	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,875.54	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	622,102.87	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,401.68	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	54,307.71	9,058.51
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	2,873.31	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	45,383.53	17,499.10			
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	1,067.84	0.00			
			TOTAL ANCILLARY	1,350,871.67	38,885.09
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,350,871.67	38,885.09

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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WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/16	THROUGH	06/30/16
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

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/16 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	185,556.28	ADJUSTMENTS	6,128.86
COVERED CHARGES	152,373.31	CONTRACTUAL ALLOW	140,103.59
NON-COVERD CHARGES	33,182.97	TOTAL MEDICAID LIAB	12,269.72
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	12,257.72

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

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

WELLSTAR ATLANTA MEDICAL CENTER, INC
 303 PARKWAY DRIVE, NE
 ATLANTA, GA 30312-1212

PROVIDER NUMBER
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,050.07	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	60,504.01	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,520.67	0.00
EKG/ECG	378.21	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	12,912.65	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,663.17	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,314.86	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,077.23	449.72
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	63,041.44	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	13,221.89	19,820.60			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,601.76	0.00			
			TOTAL ANCILLARY	152,373.31	33,182.97
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	152,373.31	33,182.97

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: 08/24/2017
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/16	THROUGH	06/30/16
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: 08/24/2017
 Run Time: 04:04:28
 Page: 1

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000811A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,939,313.01	ADJUSTMENTS	258,175.42
COVERED CHARGES	1,922,994.01	CONTRACTUAL ALLOW	1,192,757.02
NON-COVERD CHARGES	16,319.00	TOTAL MEDICAID LIAB	730,236.99
		LESS: COB	7,804.18
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	722,432.81

TOTAL NUMBER OF ADMISSIONS 119

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	310		0	317,354.00		11,915.00
ROUTINE NURSERY	61		0	56,608.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	371		0	373,962.00		11,915.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	39		0	80,379.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	80,379.00		0.00
TOTAL ACCOMODATIONS	410		0	454,341.00		11,915.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	370,105.08	0.00	OTHER LAB	8,651.00	0.00
MED/SURG SUPPLY	216,219.23	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	173,752.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,229.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	62,006.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,250.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,798.00	0.00	MRI SERVICES	7,260.00	0.00
IV THERAPY	33,693.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	192,274.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	27,058.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	84,621.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	54,965.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	46,246.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	24,377.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,488.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,558.68	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,227.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	22,323.00	4,404.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	18,274.00	0.00			
AUDIOLOGY	6,080.00	0.00			
CARDIOLOGY	30,156.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	27,042.00	0.00			
			TOTAL ANCILLARY	1,468,653.01	4,404.00
			TOTAL ACCOMODATIONS	454,341.00	11,915.00
			TOTAL CHARGES	1,922,994.01	16,319.00

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

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

PROVIDER NUMBER 000000811A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	190,805.85	ADJUSTMENTS	0.00
COVERED CHARGES	187,132.85	CONTRACTUAL ALLOW	64,083.33
NON-COVERD CHARGES	3,673.00	TOTAL MEDICAID LIAB	123,049.52
		LESS: COB	123,049.52
		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	39		0	39,497.00		2,572.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	39		0	39,497.00		2,572.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1		0	2,061.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	2,061.00		0.00
TOTAL ACCOMODATIONS	40		0	41,558.00		2,572.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	43,013.23	0.00	OTHER LAB	801.00	0.00
MED/SURG SUPPLY	20,731.62	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	14,831.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,935.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,560.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	918.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	852.00	0.00	MRI SERVICES	1,860.00	0.00
IV THERAPY	2,874.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	20,842.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,515.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,244.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,782.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,019.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,297.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,624.00	1,101.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,876.00	0.00			
			TOTAL ANCILLARY	145,574.85	1,101.00
			TOTAL ACCOMODATIONS	41,558.00	2,572.00
			TOTAL CHARGES	187,132.85	3,673.00

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: 08/24/2017
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SOUTHEAST GEORGIA HEALTH SYSTEM, INC
2000 DAN PROCTOR DR
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,659,673.22	ADJUSTMENTS	50,269.47
COVERED CHARGES	2,437,514.81	CONTRACTUAL ALLOW	1,697,189.61
NON-COVERD CHARGES	222,158.41	TOTAL MEDICAID LIAB	740,325.20
		LESS: COB	1,155.56
		LESS: COPAYMENT	2,003.26
		REIMBURSEMENT	737,166.38
		ALL OTHER	532,964.68
		FEE SCHEDULE-LAB	77,819.53
		INJECTABLE DRUGS	126,382.17

TOTAL NUMBER OF CLAIMS 2,299

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

PROVIDER NUMBER
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	90,281.32	1,760.00	OTHER LAB	44,513.00	4,806.00
MED/SURG SUPPLY	49,486.57	675.07	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	336.00	0.00
RADIOLOGY-DIAGNOSTIC	139,713.00	3,380.00	OTHER THERAPEUTIC SVC	0.00	3,388.00
CT SCAN	203,040.00	36,284.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,538.00	1,443.00	FEE SCHEDULE LAB	396,070.00	28,705.90
EKG/ECG	29,616.00	994.00	MRI SERVICES	86,128.00	4,144.00
IV THERAPY	139,400.00	13,322.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	59,816.67	4,112.33	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	14,866.00	4,013.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	15,240.00	6,481.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	22,225.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	597,481.00	10,379.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,286.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	332,255.25	80,663.11
RADIOLOGY THERAPEUTIC	33,155.00	902.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	298.00	2,591.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,828.00	129.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,312.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	30.00
OTHER IMAGING SERVICE	75,400.00	5,946.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	18,849.00	3,646.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	11,603.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,372.00	1,569.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,695.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	46,711.00	2,795.00			
			TOTAL ANCILLARY	2,437,514.81	222,158.41
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,437,514.81	222,158.41

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: 08/24/2017
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SOUTHEAST GEORGIA HEALTH SYSTEM, INC
2000 DAN PROCTOR DR
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3008	5915295000866	07/07/15 - 07/09/15	10/26/15	0.00	30.00	0.00	0.00	0.00
TOTAL				0.00	30.00	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: 08/24/2017
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SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	43,722.62	ADJUSTMENTS	0.00
COVERED CHARGES	36,341.09	CONTRACTUAL ALLOW	11,710.89
NON-COVERD CHARGES	7,381.53	TOTAL MEDICAID LIAB	24,630.20
		LESS: COB	24,618.20
		LESS: COPAYMENT	12.00
		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

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

PROVIDER NUMBER
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,072.88	0.00	OTHER LAB	462.00	0.00
MED/SURG SUPPLY	1,568.76	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	129.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,424.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,400.00	2,375.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,924.00	460.00
EKG/ECG	426.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,316.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,054.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	230.00	395.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	696.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,587.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	604.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	412.45	2,974.53
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	922.00	1,048.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	242.00	0.00			
			TOTAL ANCILLARY	36,341.09	7,381.53
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	36,341.09	7,381.53

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: 08/24/2017
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SOUTHEAST GEORGIA HEALTH SYSTEM, INC
2000 DAN PROCTOR DR
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	237,130.76	ADJUSTMENTS	267.70
COVERED CHARGES	225,521.71	CONTRACTUAL ALLOW	206,278.35
NON-COVERD CHARGES	11,609.05	TOTAL MEDICAID LIAB	19,243.36
		LESS: COB	0.00
		LESS: COPAYMENT	557.44
		REIMBURSEMENT	18,685.92
		TOTAL NUMBER OF CLAIMS	344

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,794.06	263.60	OTHER LAB	2,403.00	0.00
MED/SURG SUPPLY	402.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,909.00	213.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,810.00	4,990.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	34,361.00	2,768.00
EKG/ECG	1,704.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,009.00	410.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	230.00	165.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	750.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	136,181.00	242.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,052.35	1,678.45
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	5,916.00	879.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	225,521.71	11,609.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	225,521.71	11,609.05

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

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

Run Date: 08/24/2017
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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,764.05	ADJUSTMENTS	0.00
COVERED CHARGES	10,310.05	CONTRACTUAL ALLOW	4,238.11
NON-COVERD CHARGES	2,454.00	TOTAL MEDICAID LIAB	6,071.94
		LESS: COB	6,062.94
		LESS: COPAYMENT	9.00
		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: 08/24/2017
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	179.65	0.00	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	794.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,459.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,079.00	702.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,623.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	280.40	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	293.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	10,310.05	2,454.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,310.05	2,454.00

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: 08/24/2017
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	164,658.11	ADJUSTMENTS	11,771.68
COVERED CHARGES	145,988.96	CONTRACTUAL ALLOW	98,345.44
NON-COVERD CHARGES	18,669.15	TOTAL MEDICAID LIAB	47,643.52
		LESS: COB	0.00
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	47,625.52

TOTAL NUMBER OF CLAIMS 8

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

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

PROVIDER NUMBER
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,849.58	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	14,159.83	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	121.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	420.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,670.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,603.25	7,206.50	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	3,293.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	605.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	106,183.30	11,341.65
RADIOLOGY THERAPEUTIC	6,206.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	999.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	145,988.96	18,669.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	145,988.96	18,669.15

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

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

PROVIDER NUMBER
000000811A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/15	THROUGH	04/30/16
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000822A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,448,854.03	ADJUSTMENTS	2,210,768.83
COVERED CHARGES	23,103,888.21	CONTRACTUAL ALLOW	15,500,975.90
NON-COVERD CHARGES	344,965.82	TOTAL MEDICAID LIAB	7,602,912.31
		LESS: COB	57,039.37
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,545,872.94

TOTAL NUMBER OF ADMISSIONS 810

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,077		10	3,161,194.00		106,979.00
ROUTINE NURSERY	260		0	241,946.00		258.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,337		10	3,403,140.00		107,237.00
SPECIAL CARE SERVICES						
CCU	244		0	502,925.00		0.00
ICU	1,414		0	2,396,147.60		28.40
NICU	26		0	43,706.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	22		0	34,122.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,706		0	2,976,900.60		28.40
TOTAL ACCOMODATIONS	5,043		10	6,380,040.60		107,265.40

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,230,275.59	177.80	OTHER LAB	74,332.00	0.00
MED/SURG SUPPLY	1,822,153.15	2,229.26	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,756,993.00	17,821.00	EDUCATION & TRAINING	969.00	0.00
RADIOLOGY-DIAGNOSTIC	304,567.00	0.00	OTHER THERAPEUTIC SVC	0.00	599.00
CT SCAN	373,938.00	111,736.36	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	143,664.15	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	76,395.00	0.00	MRI SERVICES	159,018.00	0.00
IV THERAPY	335,123.00	16,051.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,133,503.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	118,305.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,099,699.00	63.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	412,617.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	964.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	312,240.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	154,360.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,269.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	36,766.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	99,196.08	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	28,598.04	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	285,088.00	19,970.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	377.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	68,535.60	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	7,260.00
OTHER IMAGING SERVICE	52,645.00	3,885.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	434,455.00	50,646.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	74,430.00	6,885.00			
AUDIOLOGY	28,785.00	0.00			
CARDIOLOGY	991,338.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	34,001.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	79,625.00	0.00			
			TOTAL ANCILLARY	16,723,847.61	237,700.42
			TOTAL ACCOMODATIONS	6,380,040.60	107,265.40
			TOTAL CHARGES	23,103,888.21	344,965.82

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

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2216112016802	10/29/15 - 11/03/15	04/25/16	0.00	2,700.00	0.00	0.00	0.00
615	2216138010597	02/20/16 - 02/23/16	05/23/16	0.00	2,700.00	0.00	0.00	0.00
615	2217116002263	12/11/15 - 12/18/15	05/01/17	0.00	1,860.00	0.00	0.00	0.00
TOTAL				0.00	7,260.00	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

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

PROVIDER NUMBER
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	265,644.88	ADJUSTMENTS	0.00
COVERED CHARGES	262,093.88	CONTRACTUAL ALLOW	69,059.08
NON-COVERD CHARGES	3,551.00	TOTAL MEDICAID LIAB	193,034.80
		LESS: COB	193,034.80
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 19

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	44		0	45,169.00		3,436.00
ROUTINE NURSERY	14		0	12,992.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	58		0	58,161.00		3,436.00
SPECIAL CARE SERVICES						
CCU	1		0	2,061.00		0.00
ICU	3		0	5,163.00		0.00
NICU	1		0	1,681.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	5		0	8,905.00		0.00
TOTAL ACCOMODATIONS	63		0	67,066.00		3,436.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,005.31	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	11,227.53	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	19,963.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,605.00	0.00	OTHER THERAPEUTIC SVC	0.00	115.00
CT SCAN	1,602.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	355.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	426.00	0.00	MRI SERVICES	2,700.00	0.00
IV THERAPY	205.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	60,629.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,446.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	368.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	14,462.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,949.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,507.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	298.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	209.02	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,848.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	13,556.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,525.00	0.00			
AUDIOLOGY	1,823.00	0.00			
CARDIOLOGY	4,373.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,946.00	0.00			
			TOTAL ANCILLARY	195,027.88	115.00
			TOTAL ACCOMODATIONS	67,066.00	3,436.00
			TOTAL CHARGES	262,093.88	3,551.00

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: 08/24/2017
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SOUTHEAST GEORGIA HEALTH SYSTEM INC
2415 PARKWOOD DRIVE
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,477,202.12	ADJUSTMENTS	340,903.50
COVERED CHARGES	10,179,081.11	CONTRACTUAL ALLOW	7,655,693.91
NON-COVERD CHARGES	1,298,121.01	TOTAL MEDICAID LIAB	2,523,387.20
		LESS: COB	2,391.93
		LESS: COPAYMENT	9,780.28
		REIMBURSEMENT	2,511,214.99
		ALL OTHER	1,863,640.14
		FEE SCHEDULE-LAB	239,879.04
		INJECTABLE DRUGS	407,695.81

TOTAL NUMBER OF CLAIMS 6,863

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

PROVIDER NUMBER
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	439,498.23	17,750.89	OTHER LAB	117,099.00	10,463.00
MED/SURG SUPPLY	528,763.15	4,576.48	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	224.00	EDUCATION & TRAINING	504.00	57.00
RADIOLOGY-DIAGNOSTIC	452,440.00	12,439.00	OTHER THERAPEUTIC SVC	0.00	12,226.00
CT SCAN	657,707.00	116,325.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	43,121.00	22,109.00	FEE SCHEDULE LAB	1,243,366.80	74,122.00
EKG/ECG	86,361.00	4,758.00	MRI SERVICES	282,808.00	22,554.00
IV THERAPY	465,914.00	27,850.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	945,565.50	147,948.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	17,184.50	4,063.50	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	351,222.00	85,155.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	158,777.00	696.00	AMBULANCE	0.00	0.00
GI SERVICES	26,927.00	6,368.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,386,142.00	26,615.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	112,898.00	510.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,247,587.93	446,025.06
RADIOLOGY THERAPEUTIC	699,092.00	93,990.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	990.00	3,792.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	850.00	627.06	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,403.00	252.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	408.00	1,732.50
LITHOTRIPSY	29,070.00	0.00	NO CC/INVALID REV CODE	0.00	36.00
OTHER IMAGING SERVICE	343,107.00	54,121.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	63,612.00	18,408.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	75,172.00	17,161.00			
AUDIOLOGY	0.00	190.00			
CARDIOLOGY	109,257.00	55,349.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	15,299.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	270,935.00	9,627.00			
			TOTAL ANCILLARY	10,179,081.11	1,298,121.01
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,179,081.11	1,298,121.01

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: 08/24/2017
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SOUTHEAST GEORGIA HEALTH SYSTEM INC
2415 PARKWOOD DRIVE
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3008	2216054006577	01/08/16 - 01/08/16	02/29/16	0.00	36.00	0.00	0.00	0.00
TOTAL				0.00	36.00	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

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

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	265,652.42	ADJUSTMENTS	0.00
COVERED CHARGES	163,364.72	CONTRACTUAL ALLOW	32,388.10
NON-COVERD CHARGES	102,287.70	TOTAL MEDICAID LIAB	130,976.62
		LESS: COB	130,852.58
		LESS: COPAYMENT	124.04
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 109

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

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

PROVIDER NUMBER
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,104.56	435.85	OTHER LAB	5,474.00	0.00
MED/SURG SUPPLY	11,325.51	1,296.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,411.00	0.00	OTHER THERAPEUTIC SVC	0.00	605.00
CT SCAN	6,179.00	12,746.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	19,842.00	1,668.00
EKG/ECG	1,136.00	0.00	MRI SERVICES	2,454.00	5,070.00
IV THERAPY	23,580.00	426.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,956.50	6,378.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,840.00	395.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	600.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,142.00	348.00	AMBULANCE	0.00	0.00
GI SERVICES	656.00	973.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,191.00	1,487.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,342.00	302.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,953.15	57,465.75
RADIOLOGY THERAPEUTIC	97.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	763.50
OTHER IMAGING SERVICE	3,202.00	6,446.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	677.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,515.00	121.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	715.00	1,569.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,649.00	3,115.00			
			TOTAL ANCILLARY	163,364.72	102,287.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	163,364.72	102,287.70

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

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3606	2215198017820	05/18/15 - 05/18/15	07/20/15	0.00	763.50	0.00	2,653.25	0.00
TOTAL				0.00	763.50	0.00	2,653.25	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: 08/24/2017
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SOUTHEAST GEORGIA HEALTH SYSTEM INC
2415 PARKWOOD DRIVE
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	483,485.22	ADJUSTMENTS	483.16
COVERED CHARGES	448,393.39	CONTRACTUAL ALLOW	417,850.15
NON-COVERD CHARGES	35,091.83	TOTAL MEDICAID LIAB	30,543.24
		LESS: COB	48.41
		LESS: COPAYMENT	1,086.38
		REIMBURSEMENT	29,408.45
		TOTAL NUMBER OF CLAIMS	546

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,054.34	527.20	OTHER LAB	3,573.00	1,602.00
MED/SURG SUPPLY	4,072.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	24,120.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	41,278.00	11,777.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	66,303.00	6,315.00
EKG/ECG	2,840.00	0.00	MRI SERVICES	4,390.00	2,700.00
IV THERAPY	18,898.00	1,230.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,216.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	600.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	505.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	224,361.00	1,019.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	208.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,105.65	6,175.63
RADIOLOGY THERAPEUTIC	12,185.00	599.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,276.00	3,147.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,408.00	0.00			
			TOTAL ANCILLARY	448,393.39	35,091.83
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	448,393.39	35,091.83

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

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

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,205.45	ADJUSTMENTS	0.00
COVERED CHARGES	10,086.55	CONTRACTUAL ALLOW	2,848.23
NON-COVERD CHARGES	3,118.90	TOTAL MEDICAID LIAB	7,238.32
		LESS: COB	7,223.32
		LESS: COPAYMENT	15.00
		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

Run Date: 08/24/2017
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SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	451.55	0.00	OTHER LAB	0.00	801.00
MED/SURG SUPPLY	0.00	0.00	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	0.00	975.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,349.00	80.00
EKG/ECG	142.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,062.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,594.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	181.00	338.90
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	755.00	924.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	10,086.55	3,118.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,086.55	3,118.90

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

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

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,847,653.58	ADJUSTMENTS	107,261.58
COVERED CHARGES	1,759,092.46	CONTRACTUAL ALLOW	1,356,913.18
NON-COVERD CHARGES	88,561.12	TOTAL MEDICAID LIAB	402,179.28
		LESS: COB	39,510.10
		LESS: COPAYMENT	341.92
		REIMBURSEMENT	362,327.26
		TOTAL NUMBER OF CLAIMS	66

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

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

PROVIDER NUMBER
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,703.58	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	519,515.11	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	57.00
RADIOLOGY-DIAGNOSTIC	5,493.00	386.00	OTHER THERAPEUTIC SVC	0.00	1,210.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,007.02	FEE SCHEDULE LAB	3,952.00	335.00
EKG/ECG	852.00	924.00	MRI SERVICES	0.00	0.00
IV THERAPY	49,207.00	1,283.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	292,340.00	38,090.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	25,760.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,306.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,886.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	658,943.27	25,458.10
RADIOLOGY THERAPEUTIC	64,884.00	1,496.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,238.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	47,107.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,101.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	57,216.00	16,956.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,826.00	121.00			
			TOTAL ANCILLARY	1,759,092.46	88,561.12
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,759,092.46	88,561.12

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: 08/24/2017
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER
000000822A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/15	THROUGH	04/30/16
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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,339,263.79	ADJUSTMENTS	145,142.66
COVERED CHARGES	12,745,478.74	CONTRACTUAL ALLOW	10,111,808.35
NON-COVERD CHARGES	593,785.05	TOTAL MEDICAID LIAB	2,633,670.39
		LESS: COB	8,305.94
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,625,364.45

TOTAL NUMBER OF ADMISSIONS 379

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	630		0	458,070.00		40,373.40
ROUTINE NURSERY	103		0	61,207.00		103.44
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	733		0	519,277.00		40,476.84
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	671		0	1,267,716.92		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		1	0.00		565.30
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	671		1	1,267,716.92		565.30
TOTAL ACCOMODATIONS	1,404		1	1,786,993.92		41,042.14

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	306,064.52	0.00	OTHER LAB	31,870.74	0.00
MED/SURG SUPPLY	160,502.31	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,402,260.09	0.00	EDUCATION & TRAINING	200.00	0.00
RADIOLOGY-DIAGNOSTIC	276,838.65	0.00	OTHER THERAPEUTIC SVC	0.00	25,175.71
CT SCAN	358,092.88	479,111.30	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	120,289.48	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	225,149.72	0.00	MRI SERVICES	99,798.31	0.00
IV THERAPY	104,142.17	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,343,166.79	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	175,490.62	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,077,541.53	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	273,631.10	0.00	AMBULANCE	0.00	0.00
GI SERVICES	40,204.76	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	500,355.10	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	66,184.12	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	63,920.50	0.00	INJECTABLE DRUGS	1,892,949.31	0.00
RADIOLOGY THERAPEUTIC	1,797.76	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,609.55	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	310.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	802,221.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	11,309.00
OTHER IMAGING SERVICE	98,926.93	20,667.69			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	58,061.13	4,589.88			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	73,477.08	11,889.33			
AUDIOLOGY	7,840.80	0.00			
CARDIOLOGY	387,546.63	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,184.76	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,855.98	0.00			
			TOTAL ANCILLARY	10,958,484.82	552,742.91
			TOTAL ACCOMODATIONS	1,786,993.92	41,042.14
			TOTAL CHARGES	12,745,478.74	593,785.05

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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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016082061605	03/10/16 - 03/15/16	03/28/16	0.00	2,827.25	0.00	0.00	0.00
615	2216104005428	03/31/16 - 04/01/16	04/18/16	0.00	2,827.25	0.00	0.00	0.00
615	2016193024003	06/30/16 - 07/03/16	07/18/16	0.00	2,827.25	0.00	0.00	0.00
615	2016259078595	08/31/16 - 09/08/16	09/19/16	0.00	2,827.25	0.00	0.00	0.00
TOTAL				0.00	11,309.00	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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	44,891.03	ADJUSTMENTS	0.00
COVERED CHARGES	44,362.31	CONTRACTUAL ALLOW	17,113.22
NON-COVERD CHARGES	528.72	TOTAL MEDICAID LIAB	27,249.09
		LESS: COB	27,249.09
		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	4		0	2,636.00		528.72
ROUTINE NURSERY	3		0	1,776.90		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	7		0	4,412.90		528.72
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	2		0	2,469.94		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	2,469.94		0.00
TOTAL ACCOMODATIONS	9		0	6,882.84		528.72

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	786.98	0.00	OTHER LAB	400.99	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,865.95	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	568.21	0.00	OTHER THERAPEUTIC SVC	0.00	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	897.44	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,623.51	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,821.12	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,933.47	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,140.14	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,290.35	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	738.12	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,489.82	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	760.02	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	163.35	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	37,479.47	0.00
			TOTAL ACCOMODATIONS	6,882.84	528.72
			TOTAL CHARGES	44,362.31	528.72

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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,145,258.78	ADJUSTMENTS	117,139.02
COVERED CHARGES	15,355,375.79	CONTRACTUAL ALLOW	13,741,758.04
NON-COVERD CHARGES	1,789,882.99	TOTAL MEDICAID LIAB	1,613,617.75
		LESS: COB	1,383.46
		LESS: COPAYMENT	5,417.71
		REIMBURSEMENT	1,606,816.58
		ALL OTHER	1,310,274.78
		FEE SCHEDULE-LAB	178,163.48
		INJECTABLE DRUGS	118,378.32
		TOTAL NUMBER OF CLAIMS	5,104

SUMMARY TYPE III
 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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,500.95	42,649.04	OTHER LAB	60,225.16	0.00
MED/SURG SUPPLY	201,796.75	2,379.79	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	80.00
RADIOLOGY-DIAGNOSTIC	660,600.18	17,813.26	OTHER THERAPEUTIC SVC	0.00	224,873.33
CT SCAN	2,601,804.27	252,274.08	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	100,914.30	6,334.69	FEE SCHEDULE LAB	3,007,150.67	207,073.70
EKG/ECG	254,751.66	7,652.88	MRI SERVICES	367,877.30	28,088.51
IV THERAPY	396,950.18	43,843.96	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,337,138.79	154,896.70	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	13,795.31	394.01	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	47,927.77	7,343.22	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	292,010.10	9,798.26	AMBULANCE	0.00	0.00
GI SERVICES	54,113.61	11,021.61	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,921,895.40	18,270.98	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	95,822.67	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,155,325.58	208,048.61
RADIOLOGY THERAPEUTIC	692,664.60	165,522.59	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,323.46	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	134,442.57	5,943.12	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	14,437.25	159,447.22
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	291,211.22	58,961.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	17,515.41	32,129.16			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	205,662.98	84,619.03			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	150,176.51	39,099.98			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	148,230.74	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	101,433.86	0.00			
			TOTAL ANCILLARY	15,355,375.79	1,789,882.99
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,355,375.79	1,789,882.99

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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	210,748.15	ADJUSTMENTS	0.00
COVERED CHARGES	139,020.02	CONTRACTUAL ALLOW	62,893.63
NON-COVERD CHARGES	71,728.13	TOTAL MEDICAID LIAB	76,126.39
		LESS: COB	76,089.45
		LESS: COPAYMENT	36.94
		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

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,276.39	197.13	OTHER LAB	400.99	0.00
MED/SURG SUPPLY	3,502.74	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,488.31	0.00	OTHER THERAPEUTIC SVC	0.00	441.96
CT SCAN	13,382.37	19,886.56	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	35,473.89	4,227.68
EKG/ECG	1,700.64	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,231.33	805.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,623.51	17,621.57	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	788.02	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	178.11	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,048.47	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,664.62	CAST ROOM	0.00	0.00
EMERGENCY ROOM	44,841.69	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,476.24	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,026.07	17,479.99
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	905.53
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,481.41	5,444.32			
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	3,053.77			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,099.84	0.00			
			TOTAL ANCILLARY	139,020.02	71,728.13
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	139,020.02	71,728.13

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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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	705,741.40	ADJUSTMENTS	273.70
COVERED CHARGES	667,116.57	CONTRACTUAL ALLOW	643,621.77
NON-COVERD CHARGES	38,624.83	TOTAL MEDICAID LIAB	23,494.80
		LESS: COB	8.56
		LESS: COPAYMENT	810.12
		REIMBURSEMENT	22,676.12
		TOTAL NUMBER OF CLAIMS	420

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	155.50	689.59	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	139.69	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	29,822.35	0.00	OTHER THERAPEUTIC SVC	0.00	9,596.00
CT SCAN	65,199.77	9,976.42	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	136,294.77	8,309.14
EKG/ECG	5,952.24	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	22,987.68	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	356.22	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	364,036.36	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	27,875.79	1,499.55
RADIOLOGY THERAPEUTIC	4,122.07	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,313.82	8,414.44			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	667,116.57	38,624.83
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	667,116.57	38,624.83

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

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

Run Date: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,513.03	ADJUSTMENTS	0.00
COVERED CHARGES	17,619.68	CONTRACTUAL ALLOW	11,715.54
NON-COVERD CHARGES	893.35	TOTAL MEDICAID LIAB	5,904.14
		LESS: COB	5,898.14
		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

Run Date: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	68.86	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,082.32	0.00	OTHER THERAPEUTIC SVC	0.00	441.96
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,807.43	413.31
EKG/ECG	850.32	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,498.50	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	312.25	38.08
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	17,619.68	893.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,619.68	893.35

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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,468,475.24	ADJUSTMENTS	16,608.69
COVERED CHARGES	1,381,162.29	CONTRACTUAL ALLOW	1,137,172.16
NON-COVERD CHARGES	87,312.95	TOTAL MEDICAID LIAB	243,990.13
		LESS: COB	0.00
		LESS: COPAYMENT	397.06
		REIMBURSEMENT	243,593.07
		TOTAL NUMBER OF CLAIMS	44

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1.78	2,861.77	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	53,516.38
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,320.35	202.10
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	72,992.63	441.96	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	1,174,927.50	30,290.74
RADIOLOGY THERAPEUTIC	127,578.29	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	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	341.74	0.00			
			TOTAL ANCILLARY	1,381,162.29	87,312.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,381,162.29	87,312.95

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: 08/24/2017
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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	01/01/16	THROUGH	12/31/16
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: 08/24/2017
 Run Time: 03:02:36
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,704,952.65	ADJUSTMENTS	175,169.62
COVERED CHARGES	1,701,294.65	CONTRACTUAL ALLOW	875,260.77
NON-COVERD CHARGES	3,658.00	TOTAL MEDICAID LIAB	826,033.88
		LESS: COB	2,258.99
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	823,774.89

TOTAL NUMBER OF ADMISSIONS 175

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	365		0	221,817.00		2,785.00
ROUTINE NURSERY	123		0	59,926.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	488		0	281,743.00		2,785.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	30		0	42,930.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	42,930.00		0.00
TOTAL ACCOMODATIONS	518		0	324,673.00		2,785.00

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	285,796.52	0.00	OTHER LAB	3,322.00	0.00
MED/SURG SUPPLY	160,988.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	261,751.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,863.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	74,150.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,485.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	5,061.00	0.00	MRI SERVICES	17,647.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	174,789.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	143,109.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	57,966.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,640.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,494.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	25,305.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	15,444.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	6,496.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	9,847.08	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,724.03	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	16,012.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,581.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,277.00	852.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	18,337.00	0.00			
CARDIOLOGY	12,616.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,921.00	21.00			
			TOTAL ANCILLARY	1,376,621.65	873.00
			TOTAL ACCOMODATIONS	324,673.00	2,785.00
			TOTAL CHARGES	1,701,294.65	3,658.00

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

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

Run Date: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
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: 08/24/2017
Run Time: 03:02:39
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,784,322.98	ADJUSTMENTS	37,664.51
COVERED CHARGES	2,564,505.41	CONTRACTUAL ALLOW	1,930,817.87
NON-COVERD CHARGES	219,817.57	TOTAL MEDICAID LIAB	633,687.54
		LESS: COB	216.83
		LESS: COPAYMENT	1,806.00
		REIMBURSEMENT	631,664.71
		ALL OTHER	543,445.38
		FEE SCHEDULE-LAB	76,657.04
		INJECTABLE DRUGS	11,562.29
		TOTAL NUMBER OF CLAIMS	2,231

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: 08/24/2017
 Run Time: 03:02:39
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55,194.00	0.00	OTHER LAB	5,611.00	0.00
MED/SURG SUPPLY	116,040.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	182,897.00	580.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	322,573.00	67,219.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	46,598.00	24,343.02	FEE SCHEDULE LAB	550,045.18	23,211.70
EKG/ECG	28,164.00	1,770.00	MRI SERVICES	38,162.00	2,168.00
IV THERAPY	243,796.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	226,743.23	29,404.77	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,506.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	28,436.00	8,332.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	32,202.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	47,162.00	13,967.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	316,324.00	1,348.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	49,636.00	4,317.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	101,706.00	28,901.00
RADIOLOGY THERAPEUTIC	1,119.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	17,235.00	4,178.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	392.00	2,647.06	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,056.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	21,153.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	69.00
OTHER IMAGING SERVICE	50,891.00	2,649.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,846.00	1,467.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,885.00	174.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	59,189.00	2,016.00			
			TOTAL ANCILLARY	2,564,505.41	219,817.57
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,564,505.41	219,817.57

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

Run Date: 08/24/2017
Run Time: 03:02:39
Page: 6

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016208010756	07/19/16 - 07/19/16	08/01/16	0.00	69.00	0.00	0.00	0.00
TOTAL				0.00	69.00	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: 08/24/2017
Run Time: 03:02:49
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,623.00	ADJUSTMENTS	0.00
COVERED CHARGES	10,392.00	CONTRACTUAL ALLOW	-442.09
NON-COVERD CHARGES	6,231.00	TOTAL MEDICAID LIAB	10,834.09
		LESS: COB	10,828.09
		LESS: COPAYMENT	6.00
		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

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 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	199.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	597.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,925.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,700.00	FEE SCHEDULE LAB	3,534.00	606.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,396.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,612.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	999.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	10,392.00	6,231.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,392.00	6,231.00

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: 08/24/2017
Run Time: 03:02:50
Page: 9

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	61,345.00	ADJUSTMENTS	105.88
COVERED CHARGES	60,957.00	CONTRACTUAL ALLOW	55,027.36
NON-COVERD CHARGES	388.00	TOTAL MEDICAID LIAB	5,929.64
		LESS: COB	0.00
		LESS: COPAYMENT	138.80
		REIMBURSEMENT	5,790.84
		TOTAL NUMBER OF CLAIMS	106

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

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

Run Date: 08/24/2017
 Run Time: 03:02:50
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	892.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,533.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,596.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	19,858.00	378.00
EKG/ECG	637.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,652.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	184.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	26,289.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,819.00	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	452.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	60,957.00	388.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	60,957.00	388.00

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: 08/24/2017
Run Time: 03:02:51
Page: 11

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	10/01/15	THROUGH	09/30/16
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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	64,778.00	ADJUSTMENTS	0.00
COVERED CHARGES	59,979.00	CONTRACTUAL ALLOW	48,888.54
NON-COVERD CHARGES	4,799.00	TOTAL MEDICAID LIAB	11,090.46
		LESS: COB	0.00
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	11,072.46

TOTAL NUMBER OF CLAIMS 2

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,030.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	19,354.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	185.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	945.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,675.00	725.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	19,214.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,572.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,183.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,247.00	4,074.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,574.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	59,979.00	4,799.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	59,979.00	4,799.00

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: 08/24/2017
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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	10/01/15	THROUGH	09/30/16
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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	537,258,383.56	ADJUSTMENTS	24,759,089.47
COVERED CHARGES	518,919,227.96	CONTRACTUAL ALLOW	409,264,508.78
NON-COVERD CHARGES	18,339,155.60	TOTAL MEDICAID LIAB	109,654,719.18
		LESS: COB	393,134.21
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	109,261,584.97

TOTAL NUMBER OF ADMISSIONS 7,698

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	32,601		2	55,541,506.00		3,441,144.00
ROUTINE NURSERY	5,946		9	12,603,543.00		1,335,253.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		120,875.61
TOTAL ROUTINE	38,547		11	68,145,049.00		4,897,272.61
SPECIAL CARE SERVICES						
CCU	165		0	503,125.00		12,500.00
ICU	13,667		0	55,004,150.00		856,750.00
NICU	482		0	2,542,851.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	789		0	5,655,468.00		312,851.00
HOSPICE	0		2	0.00		5,000.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	15,103		2	63,705,594.00		1,187,101.00
TOTAL ACCOMODATIONS	53,650		13	131,850,643.00		6,084,373.61

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,279,814.11	669,121.32	OTHER LAB	2,545,487.00	21,725.00
MED/SURG SUPPLY	14,062,977.03	429,007.27	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	64,088,645.50	993,308.50	EDUCATION & TRAINING	648.00	0.00
RADIOLOGY-DIAGNOSTIC	13,270,981.50	148,441.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	29,739,170.00	1,344,894.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,542,769.97	200,353.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,605,446.00	9,359.00	MRI SERVICES	6,467,219.00	34,012.00
IV THERAPY	235,435.00	8,197.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	87,521,413.50	1,648,071.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,697,096.00	4,450.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	38,191,538.00	831,244.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	19,042,872.00	303,211.00	AMBULANCE	0.00	0.00
GI SERVICES	961,195.00	10,867.00	CAST ROOM	13,040.00	0.00
EMERGENCY ROOM	16,390,426.00	96,878.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,688,436.00	57,294.00	DRUG-SPECIFIC/HOME IV	0.00	225,096.51
LABORATORY PATHOLOGIC	1,218,946.00	25,762.00	INJECTABLE DRUGS	19,173,977.05	491,161.64
RADIOLOGY THERAPEUTIC	1,001,313.00	38,084.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,712,588.20	50,938.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,189,280.11	15,631.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	2,882,316.00	491,928.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,464.00	272,278.00	TRAUMA RESPONSE	0.00	2,077,072.00
PSYCHIATRIC SERVICES	77,731.08	0.00	IMPL DEV CHARGE PATIENTS	6,960,672.41	68,776.25
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	34,699.00
OTHER IMAGING SERVICE	2,610,874.00	246,799.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,327,177.00	1,047,275.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,158,218.00	247,272.00			
AUDIOLOGY	446,599.00	0.00			
CARDIOLOGY	9,244,930.50	27,107.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,739,021.00	84,469.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,974,868.00	0.00			
			TOTAL ANCILLARY	387,068,584.96	12,254,781.99
			TOTAL ACCOMODATIONS	131,850,643.00	6,084,373.61
			TOTAL CHARGES	518,919,227.96	18,339,155.60

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: 08/24/2017
 Run Time: 03:03:04
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016020009244	01/05/16 - 01/06/16	01/25/16	0.00	4,957.00	0.00	0.00	0.00
615	2016041007321	01/13/16 - 01/19/16	02/15/16	0.00	4,957.00	0.00	0.00	0.00
615	2016047005340	02/02/16 - 02/03/16	02/22/16	0.00	4,957.00	0.00	0.00	0.00
615	2016056114092	01/11/16 - 01/19/16	02/29/16	0.00	4,957.00	0.00	0.00	0.00
615	2016061061507	01/07/16 - 02/23/16	03/07/16	0.00	4,957.00	0.00	0.00	0.00
615	2016075007731	02/26/16 - 03/02/16	03/21/16	0.00	4,957.00	0.00	0.00	0.00
615	2016079003834	03/07/16 - 03/08/16	03/28/16	0.00	4,957.00	0.00	0.00	0.00
TOTAL				0.00	34,699.00	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: 08/24/2017
 Run Time: 03:05:40
 Page: 4

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,834,626.44	ADJUSTMENTS	0.00
COVERED CHARGES	2,789,770.44	CONTRACTUAL ALLOW	1,906,203.87
NON-COVERD CHARGES	44,856.00	TOTAL MEDICAID LIAB	883,566.57
		LESS: COB	883,566.57
		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	75		1	131,000.00		7,950.00
ROUTINE NURSERY	11		0	17,019.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	86		1	148,019.00		7,950.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	72		0	353,375.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	72		0	353,375.00		0.00
TOTAL ACCOMODATIONS	158		1	501,394.00		7,950.00

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47,626.19	0.00	OTHER LAB	4,599.00	0.00
MED/SURG SUPPLY	70,808.47	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	214,161.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	69,202.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	97,722.00	10,202.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	16,191.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,146.00	0.00	MRI SERVICES	2,461.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	848,864.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,451.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	328,751.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	194,872.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,228.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	33,596.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	24,858.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	8,228.00	0.00	INJECTABLE DRUGS	91,845.44	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	12,718.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,473.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	26,704.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	122,428.34	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,996.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	52,614.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	1,756.00	0.00			
CARDIOLOGY	10,750.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,031.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,288,376.44	36,906.00
			TOTAL ACCOMODATIONS	501,394.00	7,950.00
			TOTAL CHARGES	2,789,770.44	44,856.00

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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	142,114,629.96	ADJUSTMENTS	1,904,267.74
COVERED CHARGES	124,232,585.01	CONTRACTUAL ALLOW	101,684,389.25
NON-COVERD CHARGES	17,882,044.95	TOTAL MEDICAID LIAB	22,548,195.76
		LESS: COB	36,547.93
		LESS: COPAYMENT	148,000.89
		REIMBURSEMENT	22,363,646.94
		ALL OTHER	18,249,174.05
		FEE SCHEDULE-LAB	2,369,512.35
		INJECTABLE DRUGS	1,744,960.54

TOTAL NUMBER OF CLAIMS 72,959

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	722,402.04	382.03	OTHER LAB	1,754,471.00	29,786.00
MED/SURG SUPPLY	642,295.20	58,033.83	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	25.00	EDUCATION & TRAINING	0.00	16,664.00
RADIOLOGY-DIAGNOSTIC	6,234,807.00	256,833.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,591,209.00	2,101,290.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	421,332.00	47,586.10	FEE SCHEDULE LAB	30,610,604.07	1,385,891.01
EKG/ECG	924,709.00	70,861.00	MRI SERVICES	3,416,241.00	790,072.00
IV THERAPY	2,952,909.00	3,994.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,393,930.28	1,098,302.72	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	65,352.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	639,857.00	56,811.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,208,056.00	5,718.00	AMBULANCE	0.00	0.00
GI SERVICES	1,126,549.73	357,493.27	CAST ROOM	8,030.00	0.00
EMERGENCY ROOM	20,933,036.00	79,633.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	491,854.00	2,993.00	DRUG-SPECIFIC/HOME IV	13,479.46	207,500.13
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,706,353.23	1,994,766.91
RADIOLOGY THERAPEUTIC	1,773,184.00	3,896,383.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	206,312.00	42,780.04	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	47,678.00	5,713.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,377,876.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	11,531,473.00	98,200.00	TRAUMA RESPONSE	0.00	897,462.00
PSYCHIATRIC SERVICES	553,977.00	1,114,005.80	IMPL DEV CHARGE PATIENTS	210,431.00	59,389.08
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	11,638.00
OTHER IMAGING SERVICE	3,918,392.00	505,250.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	977,975.00	6,821.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,659,607.00	977,579.00			
AUDIOLOGY	18,650.00	2,318.00			
CARDIOLOGY	2,528,595.00	285,759.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	106,954.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,841,880.00	16,710.00			
			TOTAL ANCILLARY	124,232,585.01	17,862,519.95
			TOTAL ACCOMODATIONS	0.00	19,525.00
			TOTAL CHARGES	124,232,585.01	17,882,044.95

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: 08/24/2017
Run Time: 03:06:02
Page: 8

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016041014022	02/01/16 - 02/01/16	02/15/16	0.00	1,724.00	0.00	0.00	0.00
615	5916047000041	01/08/16 - 01/08/16	02/22/16	0.00	4,957.00	0.00	0.00	0.00
615	2016217012197	07/27/16 - 07/27/16	08/08/16	0.00	4,957.00	0.00	0.00	0.00
TOTAL				0.00	11,638.00	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: 08/24/2017
Run Time: 03:12:40
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	637,534.10	ADJUSTMENTS	0.00
COVERED CHARGES	329,710.49	CONTRACTUAL ALLOW	156,118.52
NON-COVERD CHARGES	307,823.61	TOTAL MEDICAID LIAB	173,591.97
		LESS: COB	173,144.39
		LESS: COPAYMENT	447.58
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 263

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,320.69	0.00	OTHER LAB	4,374.00	0.00
MED/SURG SUPPLY	359.00	376.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	28,488.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,560.00	39,002.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,228.00	0.00	FEE SCHEDULE LAB	82,101.00	8,205.00
EKG/ECG	2,101.00	0.00	MRI SERVICES	0.00	15,508.00
IV THERAPY	27,618.00	470.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,988.00	9,252.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	492.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,291.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,811.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,467.00	96,064.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	85,107.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	206.82
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,260.80	2,445.79
RADIOLOGY THERAPEUTIC	886.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,388.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	24,051.00	986.00	TRAUMA RESPONSE	0.00	7,164.00
PSYCHIATRIC SERVICES	470.00	123,772.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,418.00	1,984.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	12,904.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,415.00	0.00			
			TOTAL ANCILLARY	329,710.49	307,823.61
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	329,710.49	307,823.61

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: 08/24/2017
Run Time: 03:13:00
Page: 11

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,070,783.41	ADJUSTMENTS	746.96
COVERED CHARGES	1,961,939.62	CONTRACTUAL ALLOW	1,913,999.04
NON-COVERD CHARGES	108,843.79	TOTAL MEDICAID LIAB	47,940.58
		LESS: COB	0.00
		LESS: COPAYMENT	2,491.80
		REIMBURSEMENT	45,448.78
		TOTAL NUMBER OF CLAIMS	857

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,904.87	118.99	OTHER LAB	17,165.00	0.00
MED/SURG SUPPLY	967.00	525.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	172.00
RADIOLOGY-DIAGNOSTIC	202,014.00	4,223.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	310,373.00	49,615.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	372,456.00	23,351.00
EKG/ECG	18,909.00	955.00	MRI SERVICES	28,960.00	4,307.00
IV THERAPY	36,533.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,971.00	1,769.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	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	894,317.00	3,945.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	15,489.75	9,311.80
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	3,357.00	0.00	TRAUMA RESPONSE	0.00	3,582.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	157.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,806.00	4,012.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	15,181.00	312.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,242.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,535.00	2,645.00			
			TOTAL ANCILLARY	1,961,939.62	108,843.79
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,961,939.62	108,843.79

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

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,571.00	ADJUSTMENTS	0.00
COVERED CHARGES	11,537.00	CONTRACTUAL ALLOW	8,767.41
NON-COVERD CHARGES	34.00	TOTAL MEDICAID LIAB	2,769.59
		LESS: COB	2,763.59
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15.00	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	7,067.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	719.00	34.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,656.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	80.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	11,537.00	34.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,537.00	34.00

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

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,635,803.75	ADJUSTMENTS	593,014.45
COVERED CHARGES	15,968,640.71	CONTRACTUAL ALLOW	13,183,811.09
NON-COVERD CHARGES	667,163.04	TOTAL MEDICAID LIAB	2,784,829.62
		LESS: COB	1,181.25
		LESS: COPAYMENT	1,749.00
		REIMBURSEMENT	2,781,899.37

TOTAL NUMBER OF CLAIMS 399

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	84,373.14	0.00	OTHER LAB	1,698.00	0.00
MED/SURG SUPPLY	281,161.31	15,901.11	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	167,404.00	21,387.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	137,814.00	1,280.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	302,199.00	7,086.00
EKG/ECG	2,865.00	191.00	MRI SERVICES	14,871.00	7,141.00
IV THERAPY	244,705.00	1,070.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,533,125.54	220,896.46	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,375.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,499,123.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	35,175.00	3,426.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	532,437.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,121,184.97	148,978.35
RADIOLOGY THERAPEUTIC	316,167.00	50,130.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,205.00	0.00	TRAUMA RESPONSE	0.00	32,934.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	941,562.75	30,961.12
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,185.00	1,960.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,352.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	19,779.00	5,280.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	269,558.00	110,289.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	435,321.00	8,252.00			
			TOTAL ANCILLARY	15,968,640.71	667,163.04
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,968,640.71	667,163.04

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: 08/24/2017
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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	01/01/16	THROUGH	12/31/16
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: 08/24/2017
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
 601 S 8TH ST
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER 000000866A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,946,950.08	ADJUSTMENTS	191,727.95
COVERED CHARGES	8,813,738.89	CONTRACTUAL ALLOW	7,243,478.34
NON-COVERD CHARGES	133,211.19	TOTAL MEDICAID LIAB	1,570,260.55
		LESS: COB	5,873.98
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,564,386.57

TOTAL NUMBER OF ADMISSIONS 188

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	679		0	836,752.00		47,306.00
ROUTINE NURSERY	27		0	22,167.50		1,195.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	706		0	858,919.50		48,501.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	144		0	331,128.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	144		0	331,128.00		0.00
TOTAL ACCOMODATIONS	850		0	1,190,047.50		48,501.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
 601 S 8TH ST
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,539,865.70	2,681.41	OTHER LAB	30,261.00	0.00
MED/SURG SUPPLY	779,531.70	11,208.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,207,902.91	3,097.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	137,088.00	1,060.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	363,814.50	3,071.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	37,665.46	884.16	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	74,119.50	0.00	MRI SERVICES	56,899.50	0.00
IV THERAPY	430.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	204,923.25	1,165.55	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	61,020.75	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	777,971.75	3,349.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	107,341.50	0.00	AMBULANCE	0.00	1,207.50
GI SERVICES	27,998.25	1,548.75	CAST ROOM	0.00	0.00
EMERGENCY ROOM	509,129.25	456.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	36,062.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	12,125.82	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,287.33	0.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	24,453.87	1,145.55	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	20,154.75	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,449.50	262.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	92,083.35	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	41,039.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	53,571.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	70,455.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	296,373.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	17,351.25	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	84,892.50	0.00			
			TOTAL ANCILLARY	7,623,691.39	84,710.19
			TOTAL ACCOMODATIONS	1,190,047.50	48,501.00
			TOTAL CHARGES	8,813,738.89	133,211.19

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
 601 S 8TH ST
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER 000000866A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,148.75	ADJUSTMENTS	0.00
COVERED CHARGES	18,024.75	CONTRACTUAL ALLOW	13,718.67
NON-COVERD CHARGES	124.00	TOTAL MEDICAID LIAB	4,306.08
		LESS: COB	4,306.08
		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	2,480.00		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	2		0	2,480.00		124.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	2,480.00		124.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
 601 S 8TH ST
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,015.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,856.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,289.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,339.25	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,286.25	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	1,627.50	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	131.25	0.00			
			TOTAL ANCILLARY	15,544.75	0.00
			TOTAL ACCOMODATIONS	2,480.00	124.00
			TOTAL CHARGES	18,024.75	124.00

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: 08/24/2017
Run Time: 04:08:42
Page: 5

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,891,079.71	ADJUSTMENTS	125,978.70
COVERED CHARGES	6,227,291.96	CONTRACTUAL ALLOW	5,564,604.74
NON-COVERD CHARGES	663,787.75	TOTAL MEDICAID LIAB	662,687.22
		LESS: COB	1,523.35
		LESS: COPAYMENT	1,428.00
		REIMBURSEMENT	659,735.87
		ALL OTHER	593,817.57
		FEE SCHEDULE-LAB	54,885.49
		INJECTABLE DRUGS	11,032.81
		TOTAL NUMBER OF CLAIMS	1,686

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
 601 S 8TH ST
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	277,117.03	2,525.25	OTHER LAB	50,552.25	829.50
MED/SURG SUPPLY	414,921.86	4,299.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	4,368.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	367,962.00	1,485.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	748,171.13	146,196.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	19,671.75	5,551.54	FEE SCHEDULE LAB	933,638.67	46,389.20
EKG/ECG	113,022.00	819.00	MRI SERVICES	78,498.00	25,032.00
IV THERAPY	145,291.13	4,851.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	383,257.01	78,291.49	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	85,086.75	14,448.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	209,643.00	3,129.00	AMBULANCE	0.00	0.00
GI SERVICES	17,353.88	6,680.62	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,491,097.66	11,948.99	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	48,515.25	824.25	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	258,241.51	127,302.44
RADIOLOGY THERAPEUTIC	13,482.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,566.30	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	246.75	4,447.92	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,045.44	4,856.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	37,708.37	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	109,743.10	29,799.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	26,717.25			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	35,216.42	38,844.75			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	117,316.50	52,757.25			
AMBULATORY SURGERY	2,824.50	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	107,845.50	4,536.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	154,822.50	14,290.50			
			TOTAL ANCILLARY	6,227,291.96	663,787.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,227,291.96	663,787.75

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	75,257.92	ADJUSTMENTS	0.00
COVERED CHARGES	57,484.47	CONTRACTUAL ALLOW	48,652.46
NON-COVERD CHARGES	17,773.45	TOTAL MEDICAID LIAB	8,832.01
		LESS: COB	8,829.01
		LESS: COPAYMENT	3.00
		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

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
 601 S 8TH ST
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,995.00	0.00	OTHER LAB	829.50	0.00
MED/SURG SUPPLY	3,143.04	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,307.25	540.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,449.25	7,974.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,804.25	1,527.75
EKG/ECG	409.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,052.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,284.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	194.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,346.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,521.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,233.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,634.68	5,084.20
RADIOLOGY THERAPEUTIC	1,296.75	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,703.75	1,008.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	1,638.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	278.25	0.00			
			TOTAL ANCILLARY	57,484.47	17,773.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	57,484.47	17,773.45

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

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WELLSTAR SPALDING REGIONAL HOSPITAL, INC
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	382,887.31	ADJUSTMENTS	320.64
COVERED CHARGES	351,849.31	CONTRACTUAL ALLOW	340,717.25
NON-COVERD CHARGES	31,038.00	TOTAL MEDICAID LIAB	11,132.06
		LESS: COB	0.00
		LESS: COPAYMENT	361.54
		REIMBURSEMENT	10,770.52
		TOTAL NUMBER OF CLAIMS	199

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

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
 601 S 8TH ST
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,629.00	36.75	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,830.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	546.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	24,081.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	42,645.75	25,567.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	42,425.25	1,606.50
EKG/ECG	2,047.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	15,996.75	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	997.50	194.25	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	179,660.25	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	18,198.31	1,081.50
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	10,059.00	2,005.50			
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	278.25	0.00			
			TOTAL ANCILLARY	351,849.31	31,038.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	351,849.31	31,038.00

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

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,528.25	ADJUSTMENTS	0.00
COVERED CHARGES	4,956.00	CONTRACTUAL ALLOW	4,141.84
NON-COVERD CHARGES	572.25	TOTAL MEDICAID LIAB	814.16
		LESS: COB	814.16
		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
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 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
 601 S 8TH ST
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	210.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	299.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,296.75	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	425.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,853.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	572.25
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	871.50	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	4,956.00	572.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,956.00	572.25

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 SPALDING REGIONAL HOSPITAL, INC
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	50,237.25	ADJUSTMENTS	0.00
COVERED CHARGES	50,237.25	CONTRACTUAL ALLOW	44,796.65
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	5,440.60
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	5,437.60

TOTAL NUMBER OF CLAIMS 1

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

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
 601 S 8TH ST
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	409.50	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	294.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	49,497.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	50,237.25	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	50,237.25	0.00

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

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

Run Date: 08/24/2017
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/16	THROUGH	03/31/16
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
 601 S 8TH ST
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER 000000866A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,303,739.58	ADJUSTMENTS	139,336.03
COVERED CHARGES	10,178,911.58	CONTRACTUAL ALLOW	8,501,874.75
NON-COVERD CHARGES	124,828.00	TOTAL MEDICAID LIAB	1,677,036.83
		LESS: COB	7,089.83
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,669,947.00

TOTAL NUMBER OF ADMISSIONS 215

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	795		0	985,800.00		52,842.00
ROUTINE NURSERY	33		0	26,892.50		1,195.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	828		0	1,012,692.50		54,037.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	155		0	356,422.50		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	155		0	356,422.50		0.00
TOTAL ACCOMODATIONS	983		0	1,369,115.00		54,037.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
 601 S 8TH ST
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,663,796.59	0.00	OTHER LAB	42,477.75	0.00
MED/SURG SUPPLY	926,687.41	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,367,204.82	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	177,199.45	0.00	OTHER THERAPEUTIC SVC	0.00	357.00
CT SCAN	497,479.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	52,436.14	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	72,891.00	0.00	MRI SERVICES	149,908.92	0.00
IV THERAPY	294.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	457,546.19	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	61,965.75	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	605,010.92	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	229,993.83	0.00	AMBULANCE	0.00	1,176.00
GI SERVICES	28,386.75	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	643,403.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	60,342.52	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	26,673.15	0.00	INJECTABLE DRUGS	15,797.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	17,027.91	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	27,663.66	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	12,825.75	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,171.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	168,831.29	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	46,732.51	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	69,258.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	68,250.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	306,482.27	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,323.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	71,993.25	0.00			
			TOTAL ANCILLARY	8,809,796.58	70,791.00
			TOTAL ACCOMODATIONS	1,369,115.00	54,037.00
			TOTAL CHARGES	10,178,911.58	124,828.00

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

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

Run Date: 08/24/2017
 Run Time: 04:08:57
 Page: 3

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
 601 S 8TH ST
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	32,053.12	ADJUSTMENTS	0.00
COVERED CHARGES	31,929.12	CONTRACTUAL ALLOW	26,289.16
NON-COVERD CHARGES	124.00	TOTAL MEDICAID LIAB	5,639.96
		LESS: COB	5,639.96
		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	2,480.00		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	2		0	2,480.00		124.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	2,480.00		124.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
 601 S 8TH ST
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,277.87	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,189.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,297.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	4,079.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,641.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,415.25	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	4,567.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	850.50	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	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	131.25	0.00			
			TOTAL ANCILLARY	29,449.12	0.00
			TOTAL ACCOMODATIONS	2,480.00	124.00
			TOTAL CHARGES	31,929.12	124.00

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: 08/24/2017
Run Time: 04:08:58
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WELLSTAR SPALDING REGIONAL HOSPITAL, INC
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/16 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,920,112.34	ADJUSTMENTS	85,626.58
COVERED CHARGES	5,445,718.27	CONTRACTUAL ALLOW	4,862,049.96
NON-COVERD CHARGES	474,394.07	TOTAL MEDICAID LIAB	583,668.31
		LESS: COB	69.20
		LESS: COPAYMENT	1,269.00
		REIMBURSEMENT	582,330.11
		ALL OTHER	513,610.70
		FEE SCHEDULE-LAB	52,411.75
		INJECTABLE DRUGS	16,307.66
		TOTAL NUMBER OF CLAIMS	1,506

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
 601 S 8TH ST
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	213,470.41	0.00	OTHER LAB	35,882.96	0.00
MED/SURG SUPPLY	386,001.51	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	322,364.75	829.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	629,821.50	71,179.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	11,291.70	6,265.35	FEE SCHEDULE LAB	842,317.37	11,497.50
EKG/ECG	101,146.50	409.50	MRI SERVICES	74,308.50	12,164.25
IV THERAPY	137,213.28	162.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	309,125.43	85,205.93	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	90,720.72	871.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	177,570.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	20,183.63	5,525.62	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,295,637.00	966.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	38,241.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	250,182.78	105,965.82
RADIOLOGY THERAPEUTIC	2,856.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,738.40	1,652.70	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	4,946.55	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,664.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,815.70	3,150.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	23,363.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	58,950.51	25,326.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	44,278.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	50,142.17	22,197.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	82,355.70	67,033.10			
AMBULATORY SURGERY	5,412.75	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	122,692.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	152,911.50	1,102.50			
			TOTAL ANCILLARY	5,445,718.27	474,394.07
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,445,718.27	474,394.07

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

Run Date: 08/24/2017
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/16 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,792.88	ADJUSTMENTS	0.00
COVERED CHARGES	20,362.38	CONTRACTUAL ALLOW	19,110.58
NON-COVERD CHARGES	430.50	TOTAL MEDICAID LIAB	1,251.80
		LESS: COB	1,248.80
		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

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
 601 S 8TH ST
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	598.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	766.50	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	6,021.75	84.00
EKG/ECG	1,638.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	120.75	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	299.25	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	7,449.75	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	44.88	346.50
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	189.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,171.00	0.00			
			TOTAL ANCILLARY	20,362.38	430.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	20,362.38	430.50

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: 08/24/2017
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WELLSTAR SPALDING REGIONAL HOSPITAL, INC
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/16 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	346,619.67	ADJUSTMENTS	49.77
COVERED CHARGES	343,065.42	CONTRACTUAL ALLOW	333,947.20
NON-COVERD CHARGES	3,554.25	TOTAL MEDICAID LIAB	9,118.22
		LESS: COB	0.00
		LESS: COPAYMENT	358.16
		REIMBURSEMENT	8,760.06
		TOTAL NUMBER OF CLAIMS	163

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
 601 S 8TH ST
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,542.78	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,428.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	28,896.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	60,233.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	45,575.25	1,018.50
EKG/ECG	4,914.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	11,266.50	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	582.75	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	161,684.25	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	10,067.64	1,527.75
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	5,428.50	1,008.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	446.25	0.00			
			TOTAL ANCILLARY	343,065.42	3,554.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	343,065.42	3,554.25

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: 08/24/2017
Run Time: 04:09:07
Page: 11

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/16 THROUGH 06/30/16
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: 08/24/2017
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/16 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	122,103.11	ADJUSTMENTS	5,437.60
COVERED CHARGES	119,942.31	CONTRACTUAL ALLOW	103,620.51
NON-COVERD CHARGES	2,160.80	TOTAL MEDICAID LIAB	16,321.80
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	16,309.80
		TOTAL NUMBER OF CLAIMS	3

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

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
 601 S 8TH ST
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,066.97	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	33,034.92	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,982.00	168.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	262.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,136.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	152.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,387.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,643.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,703.92	1,992.80
RADIOLOGY THERAPEUTIC	1,428.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	866.25	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	27,935.25	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,344.00	0.00			
			TOTAL ANCILLARY	119,942.31	2,160.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	119,942.31	2,160.80

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: 08/24/2017
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/16	THROUGH	06/30/16
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: 08/24/2017
 Run Time: 03:22:21
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

HABERSHAM COUNTY MEDICAL CTR
 541 HISTORIC HWY, 441N
 DEMOREST,GA 30535-0000

PROVIDER NUMBER 000000877A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,324,559.61	ADJUSTMENTS	524,522.68
COVERED CHARGES	3,307,498.44	CONTRACTUAL ALLOW	1,756,674.50
NON-COVERD CHARGES	17,061.17	TOTAL MEDICAID LIAB	1,550,823.94
		LESS: COB	24,967.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,525,856.74

TOTAL NUMBER OF ADMISSIONS 297

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	801		0	368,460.00		0.00
ROUTINE NURSERY	187		2	56,100.00		600.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	988		2	424,560.00		600.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	84		0	92,400.00		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	84		0	92,400.00		0.00
TOTAL ACCOMODATIONS	1,072		2	516,960.00		600.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

HABERSHAM COUNTY MEDICAL CTR
 541 HISTORIC HWY, 441N
 DEMOREST,GA 30535-0000

PROVIDER NUMBER
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	304,242.39	0.00	OTHER LAB	12,447.50	0.00
MED/SURG SUPPLY	222,659.93	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	334,037.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	33,388.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	123,640.50	444.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	24,331.11	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	10,595.50	0.00	MRI SERVICES	19,045.75	0.00
IV THERAPY	476,278.00	131.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	127,754.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	255,670.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	86,380.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	50,170.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	135,515.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	81,310.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	4,591.00	0.00	INJECTABLE DRUGS	69,037.08	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,645.75	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	8,531.52	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	397.17
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	12,577.25	762.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	281,129.91	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,431.75
OTHER IMAGING SERVICE	5,324.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	18,146.25	12,672.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,051.50	622.00			
AUDIOLOGY	17,900.25	0.00			
CARDIOLOGY	16,428.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	51,706.75	0.00			
			TOTAL ANCILLARY	2,790,538.44	16,461.17
			TOTAL ACCOMODATIONS	516,960.00	600.00
			TOTAL CHARGES	3,307,498.44	17,061.17

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

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016216000449	02/04/16 - 03/01/16	08/08/16	0.00	1,431.75	0.00	0.00	0.00
TOTAL				0.00	1,431.75	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: 08/24/2017
 Run Time: 03:22:25
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SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

HABERSHAM COUNTY MEDICAL CTR
 541 HISTORIC HWY, 441N
 DEMOREST,GA 30535-0000

PROVIDER NUMBER
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	55,336.81	ADJUSTMENTS	0.00
COVERED CHARGES	54,807.40	CONTRACTUAL ALLOW	22,299.73
NON-COVERD CHARGES	529.41	TOTAL MEDICAID LIAB	32,507.67
		LESS: COB	32,507.67
		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	17		0	7,820.00		0.00
ROUTINE NURSERY	4		0	1,200.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	21		0	9,020.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	21		0	9,020.00		0.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

HABERSHAM COUNTY MEDICAL CTR
 541 HISTORIC HWY, 441N
 DEMOREST,GA 30535-0000

PROVIDER NUMBER
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,690.06	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,702.86	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,114.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	126.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,877.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	113.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,391.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,025.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	15,521.75	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	559.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,462.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,549.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	73.00	0.00	INJECTABLE DRUGS	877.73	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	1.41
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	164.50	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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	296.25	528.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	205.75	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,037.00	0.00			
			TOTAL ANCILLARY	45,787.40	529.41
			TOTAL ACCOMODATIONS	9,020.00	0.00
			TOTAL CHARGES	54,807.40	529.41

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: 08/24/2017
Run Time: 03:22:25
Page: 6

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,513,409.75	ADJUSTMENTS	54,613.10
COVERED CHARGES	3,262,031.30	CONTRACTUAL ALLOW	2,470,064.91
NON-COVERD CHARGES	251,378.45	TOTAL MEDICAID LIAB	791,966.39
		LESS: COB	1,144.90
		LESS: COPAYMENT	1,587.00
		REIMBURSEMENT	789,234.49
		ALL OTHER	697,094.48
		FEE SCHEDULE-LAB	79,944.25
		INJECTABLE DRUGS	12,195.76
		TOTAL NUMBER OF CLAIMS	2,670

HABERSHAM COUNTY MEDICAL CTR
 541 HISTORIC HWY, 441N
 DEMOREST,GA 30535-0000

PROVIDER NUMBER
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	67,078.42	182.44	OTHER LAB	55,752.25	0.00
MED/SURG SUPPLY	133,151.93	1,225.91	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	10.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	161,237.75	825.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	521,837.00	127,275.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	26,251.00	8,683.90	FEE SCHEDULE LAB	574,972.25	6,614.00
EKG/ECG	35,870.00	4,068.00	MRI SERVICES	60,341.25	3,760.50
IV THERAPY	23,168.00	911.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	95,078.00	16,641.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,594.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	22,716.00	2,302.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	44,031.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,189,078.25	8,884.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	48,896.75	816.25	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	41,198.29	10,600.68
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,622.50	2,075.75	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,884.00	3,031.01	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	22.26
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	16,904.00	8,983.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	23,235.16	7,550.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	41,345.50	8,596.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,962.50	1,056.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	17,655.25	17,186.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	12,654.00	9,626.25			
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	37,516.00	450.00			
			TOTAL ANCILLARY	3,262,031.30	251,378.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,262,031.30	251,378.45

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

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	46,441.38	ADJUSTMENTS	0.00
COVERED CHARGES	38,498.13	CONTRACTUAL ALLOW	23,013.38
NON-COVERD CHARGES	7,943.25	TOTAL MEDICAID LIAB	15,484.75
		LESS: COB	15,481.32
		LESS: COPAYMENT	3.43
		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

HABERSHAM COUNTY MEDICAL CTR
 541 HISTORIC HWY, 441N
 DEMOREST,GA 30535-0000

PROVIDER NUMBER
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	965.38	0.00	OTHER LAB	651.75	0.00
MED/SURG SUPPLY	668.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,285.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,215.50	2,698.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,648.25	581.00
EKG/ECG	791.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	154.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	724.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,872.75	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	1,103.20	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	82.25	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	574.00	773.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	1,940.75			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	913.00	1,143.75			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	654.50	0.00			
			TOTAL ANCILLARY	38,498.13	7,943.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	38,498.13	7,943.25

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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HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	236,233.28	ADJUSTMENTS	638.28
COVERED CHARGES	232,909.04	CONTRACTUAL ALLOW	215,735.46
NON-COVERD CHARGES	3,324.24	TOTAL MEDICAID LIAB	17,173.58
		LESS: COB	0.00
		LESS: COPAYMENT	630.05
		REIMBURSEMENT	16,543.53
		TOTAL NUMBER OF CLAIMS	307

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

HABERSHAM COUNTY MEDICAL CTR
 541 HISTORIC HWY, 441N
 DEMOREST,GA 30535-0000

PROVIDER NUMBER
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,859.33	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,845.28	4.08	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,819.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	28,908.50	1,900.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	30,578.25	524.00
EKG/ECG	1,921.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	964.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,988.75	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,053.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	981.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	139,629.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	369.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,454.18	239.91
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	82.25	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	747.00	574.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	789.25	0.00			
			TOTAL ANCILLARY	232,909.04	3,324.24
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	232,909.04	3,324.24

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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HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	859.00	ADJUSTMENTS	0.00
COVERED CHARGES	859.00	CONTRACTUAL ALLOW	294.00
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	565.00
		LESS: COB	559.00
		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

Run Date: 08/24/2017
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HABERSHAM COUNTY MEDICAL CTR
 541 HISTORIC HWY, 441N
 DEMOREST,GA 30535-0000

PROVIDER NUMBER
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	814.00	0.00	SPECIAL SERVICES	0.00	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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	859.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	859.00	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

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/15	THROUGH	06/30/16
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: 08/24/2017
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/15	THROUGH	06/30/16
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

NORTHEAST GEORGIA MEDICAL CENTER IN
 743 SPRING ST NE
 GAINESVILLE,GA 30501-3715

PROVIDER NUMBER 000000888A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	131,024,612.46	ADJUSTMENTS	6,058,010.47
COVERED CHARGES	128,057,420.96	CONTRACTUAL ALLOW	98,290,571.07
NON-COVERD CHARGES	2,967,191.50	TOTAL MEDICAID LIAB	29,766,849.89
		LESS: COB	160,205.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	29,606,644.21

TOTAL NUMBER OF ADMISSIONS 3,149

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	11,157	3	10,658,525.00	1,988,027.00
ROUTINE NURSERY	3,050	0	3,033,001.00	119,695.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	14,207	3	13,691,526.00	2,107,722.00
SPECIAL CARE SERVICES				
CCU	543	0	1,002,745.50	0.00
ICU	2,519	0	5,106,869.00	2,101.00
NICU	128	0	241,757.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	204	0.00	213,996.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	3,190	204	6,351,371.50	216,097.00
TOTAL ACCOMODATIONS	17,397	207	20,042,897.50	2,323,819.00

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,374,243.49	4,359.00	OTHER LAB	507,681.50	0.00
MED/SURG SUPPLY	8,719,716.00	65,658.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	14,508,236.81	21,881.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,326,658.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,819,070.00	9,098.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	572,203.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	651,181.00	0.00	MRI SERVICES	1,207,926.00	0.00
IV THERAPY	1,471,993.00	15,465.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,684,930.00	18,329.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,080,206.00	8,407.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,064,613.50	18,441.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,282,260.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,584.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,756,816.00	2,499.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,549,010.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	347,314.00	0.00	INJECTABLE DRUGS	9,695,103.66	1,143.00
RADIOLOGY THERAPEUTIC	217,374.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	199,810.00	924.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	196,647.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	763,281.00	154,644.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	24,404.00	723.00	TRAUMA RESPONSE	0.00	111,657.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,893,841.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	787,289.00	14,760.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	636,651.00	89,669.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	483,508.00	105,715.00			
AUDIOLOGY	211.00	0.00			
CARDIOLOGY	3,572,223.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	256,080.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	362,458.00	0.00			
			TOTAL ANCILLARY	108,014,523.46	643,372.50
			TOTAL ACCOMODATIONS	20,042,897.50	2,323,819.00
			TOTAL CHARGES	128,057,420.96	2,967,191.50

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

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

Run Date: 08/24/2017
 Run Time: 03:52:53
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,953,287.29	ADJUSTMENTS	0.00
COVERED CHARGES	2,460,643.41	CONTRACTUAL ALLOW	956,584.83
NON-COVERD CHARGES	492,643.88	TOTAL MEDICAID LIAB	1,504,058.58
		LESS: COB	1,504,058.58
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 184

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	316		0	245,679.00		105,632.00
ROUTINE NURSERY	240		0	160,833.00		47,238.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	556		0	406,512.00		152,870.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	22		0	46,222.00		0.00
NICU	3		0	5,211.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	25		0	51,433.00		0.00
TOTAL ACCOMODATIONS	581		0	457,945.00		152,870.00

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	338,922.41	50,984.88	OTHER LAB	1,607.00	0.00
MED/SURG SUPPLY	121,332.00	14,092.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	191,227.00	51,480.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,467.00	719.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,689.00	3,581.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,685.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,445.00	578.00	MRI SERVICES	4,634.00	0.00
IV THERAPY	3,064.00	10,473.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	259,091.00	11,698.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	265,999.00	113,394.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	89,208.00	8,336.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	183,028.00	24,654.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,026.00	5,742.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	249,152.00	9,664.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	6,371.00	2,151.00	INJECTABLE DRUGS	113,877.00	17,888.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	330.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	475.00	1,008.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	89,729.00	1,780.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	14,829.00	4,569.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,716.00	1,232.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	11,530.00	2,374.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	265.00	3,376.00			
			TOTAL ANCILLARY	2,002,698.41	339,773.88
			TOTAL ACCOMODATIONS	457,945.00	152,870.00
			TOTAL CHARGES	2,460,643.41	492,643.88

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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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	52,311,484.10	ADJUSTMENTS	923,708.03
COVERED CHARGES	44,129,103.30	CONTRACTUAL ALLOW	37,700,051.03
NON-COVERD CHARGES	8,182,380.80	TOTAL MEDICAID LIAB	6,429,052.27
		LESS: COB	13,164.03
		LESS: COPAYMENT	16,395.04
		REIMBURSEMENT	6,399,493.20
		ALL OTHER	5,427,040.03
		FEE SCHEDULE-LAB	619,345.88
		INJECTABLE DRUGS	353,107.29
		TOTAL NUMBER OF CLAIMS	13,829

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,671,446.13	4,370.00	OTHER LAB	470,195.00	901.00
MED/SURG SUPPLY	1,142,263.00	381,771.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	2,756.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,408,411.00	9,026.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,931,502.00	743,702.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	134,269.00	27,544.00	FEE SCHEDULE LAB	7,351,446.17	431,907.00
EKG/ECG	608,158.00	18,207.00	MRI SERVICES	1,190,805.00	129,252.00
IV THERAPY	1,901,572.00	319,070.00	PROFESSIONAL FEES	0.00	200.00
OPERATING ROOM	3,281,026.00	555,884.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	86,243.00	335.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	248,093.00	126,104.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,043,561.00	2,626.00	AMBULANCE	0.00	0.00
GI SERVICES	15,114.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,689,160.00	6,568.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,215,473.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,203,186.00	1,134,405.80
RADIOLOGY THERAPEUTIC	2,374,059.00	828,458.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	59,731.00	19,544.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	18,098.00	13,792.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	26,078.00	PATIENT CONVENIENCE	0.00	244.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	8,170.00	TRAUMA RESPONSE	0.00	60,667.00
PSYCHIATRIC SERVICES	11,236.00	0.00	IMPL DEV CHARGE PATIENTS	32,320.00	2,179,668.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,746,077.00	117,352.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	85,128.00	49,753.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	844,192.00	339,990.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,635,265.00	595,271.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	682,646.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,048,428.00	48,765.00			
			TOTAL ANCILLARY	44,129,103.30	8,182,380.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	44,129,103.30	8,182,380.80

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,180,947.81	ADJUSTMENTS	0.00
COVERED CHARGES	934,921.81	CONTRACTUAL ALLOW	487,419.09
NON-COVERD CHARGES	246,026.00	TOTAL MEDICAID LIAB	447,502.72
		LESS: COB	447,249.83
		LESS: COPAYMENT	252.89
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 280

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,079.00	1,745.00	OTHER LAB	6,446.00	0.00
MED/SURG SUPPLY	36,017.00	3,324.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	34,771.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	43,231.00	38,227.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	157,057.00	13,683.00
EKG/ECG	17,986.00	1,156.00	MRI SERVICES	22,140.00	0.00
IV THERAPY	33,782.00	3,473.00	PROFESSIONAL FEES	0.00	350.00
OPERATING ROOM	115,952.00	55,652.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	10,428.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,891.00	573.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	47,490.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	163,651.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	50,880.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,776.81	17,749.00
RADIOLOGY THERAPEUTIC	35,598.00	36,435.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,012.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	95.00	TRAUMA RESPONSE	0.00	6,979.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	156.00	6,614.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	40,205.00	5,309.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,776.00	7,900.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	14,261.00	13,852.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	15,825.00	26,445.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,788.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	26,735.00	2,453.00			
			TOTAL ANCILLARY	934,921.81	246,026.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	934,921.81	246,026.00

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,884,983.00	ADJUSTMENTS	1,070.80
COVERED CHARGES	1,728,375.00	CONTRACTUAL ALLOW	1,667,624.16
NON-COVERD CHARGES	156,608.00	TOTAL MEDICAID LIAB	60,750.84
		LESS: COB	46.01
		LESS: COPAYMENT	1,898.81
		REIMBURSEMENT	58,806.02
		TOTAL NUMBER OF CLAIMS	1,086

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	44,740.00	1.00	OTHER LAB	2,348.00	0.00
MED/SURG SUPPLY	10,456.00	3,563.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	140,094.00	2,074.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	101,153.00	18,578.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	273,089.00	20,351.00
EKG/ECG	28,900.00	0.00	MRI SERVICES	2,872.00	7,737.00
IV THERAPY	88,939.00	3,686.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,996.00	16,942.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,419.00	564.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,837.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	926,575.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,512.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	29,160.00	1,039.00
RADIOLOGY THERAPEUTIC	17,519.00	68,012.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	95.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	17,122.00	1,904.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,584.00	7,428.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,835.00	4,369.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,225.00	265.00			
			TOTAL ANCILLARY	1,728,375.00	156,608.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,728,375.00	156,608.00

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	77,158.00	ADJUSTMENTS	0.00
COVERED CHARGES	63,548.00	CONTRACTUAL ALLOW	38,152.42
NON-COVERD CHARGES	13,610.00	TOTAL MEDICAID LIAB	25,395.58
		LESS: COB	25,359.58
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	23

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

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

Run Date: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,226.00	3.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	116.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,172.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,250.00	12,163.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,365.00	956.00
EKG/ECG	1,445.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,267.00	352.00	PROFESSIONAL FEES	0.00	50.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	291.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	24,070.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	346.00	86.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	63,548.00	13,610.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	63,548.00	13,610.00

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

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,226,762.17	ADJUSTMENTS	135,465.50
COVERED CHARGES	5,271,491.17	CONTRACTUAL ALLOW	4,600,498.31
NON-COVERD CHARGES	955,271.00	TOTAL MEDICAID LIAB	670,992.86
		LESS: COB	16,422.09
		LESS: COPAYMENT	1,094.58
		REIMBURSEMENT	653,476.19
		TOTAL NUMBER OF CLAIMS	120

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

NORTHEAST GEORGIA MEDICAL CENTER IN	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
743 SPRING ST NE	000000888A	SERVICE DATES	10/01/15	THROUGH	09/30/16
GAINESVILLE,GA 30501-3715		ADMISSION DATES	00/00/00	THROUGH	00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	174,416.02	1,439.00	OTHER LAB	4,827.00	0.00
MED/SURG SUPPLY	255,665.00	239,100.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	53,399.00	846.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	63,507.00	10,147.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	98,209.00	10,391.00
EKG/ECG	12,427.00	867.00	MRI SERVICES	16,514.00	6,382.00
IV THERAPY	160,441.00	13,180.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,012,932.00	20,470.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	22,946.00	2,871.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	212,840.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,740.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	189,667.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,304,277.15	50,140.00
RADIOLOGY THERAPEUTIC	386,998.00	165,172.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,006.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	190.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	26,955.00	381,227.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,511.00	799.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,464.00	3,160.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	12,915.00	2,005.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	207,259.00	43,211.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,014.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	27,568.00	1,668.00			
			TOTAL ANCILLARY	5,271,491.17	955,271.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,271,491.17	955,271.00

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

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	43,882.00	ADJUSTMENTS	0.00
COVERED CHARGES	42,608.00	CONTRACTUAL ALLOW	20,298.44
NON-COVERD CHARGES	1,274.00	TOTAL MEDICAID LIAB	22,309.56
		LESS: COB	22,303.56
		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

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,620.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	13,292.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	453.00	816.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	522.00	458.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,942.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,300.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,368.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	111.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	42,608.00	1,274.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	42,608.00	1,274.00

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

HAMILTON MEDICAL CENTER
 1200 MEMORIAL DR
 DALTON,GA 30720-2529

PROVIDER NUMBER 000000899A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	31,545,179.64	ADJUSTMENTS	929,976.25
COVERED CHARGES	31,015,167.37	CONTRACTUAL ALLOW	23,218,381.63
NON-COVERD CHARGES	530,012.27	TOTAL MEDICAID LIAB	7,796,785.74
		LESS: COB	104,172.06
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,692,613.68

TOTAL NUMBER OF ADMISSIONS 1,224

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,303	0	3,973,964.00	96,477.00
ROUTINE NURSERY	1,249	0	1,465,559.00	91,402.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4,552	0	5,439,523.00	187,879.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	517	0	1,428,408.00	27,560.00
NICU	190	0	665,228.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	707	0	2,093,636.00	27,560.00
TOTAL ACCOMODATIONS	5,259	0	7,533,159.00	215,439.00

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,368,866.14	5,041.23	OTHER LAB	133,977.00	0.00
MED/SURG SUPPLY	1,349,501.81	16,645.19	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,600,501.43	56,187.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	578,337.00	7,011.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,196,466.00	21,268.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	133,568.19	626.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	261,390.00	0.00	MRI SERVICES	404,564.00	0.00
IV THERAPY	395,247.00	2,151.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,177,998.00	34,689.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,682,163.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,090,625.00	13,755.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	100,786.00	669.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	813,336.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	197,689.00	1,575.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	90,017.30	0.00	INJECTABLE DRUGS	416,774.95	88.85
RADIOLOGY THERAPEUTIC	156,339.00	2,024.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	54,281.02	189.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	68,056.37	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	282,304.00	29,272.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	13,471.00	1,649.00	TRAUMA RESPONSE	0.00	18,181.00
PSYCHIATRIC SERVICES	249,855.00	0.00	IMPL DEV CHARGE PATIENTS	555,204.16	0.00
LITHOTRIPSY	23,944.00	0.00	NO CC/INVALID REV CODE	0.00	78,087.00
OTHER IMAGING SERVICE	226,622.00	13,371.00			
BLOOD	172,836.00	0.00			
BLOOD STORAGE & PRO.	144,156.00	11,830.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	144,916.00	139.00			
AUDIOLOGY	43,813.00	125.00			
CARDIOLOGY	1,273,626.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	45,528.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	35,249.00	0.00			
			TOTAL ANCILLARY	23,482,008.37	314,573.27
			TOTAL ACCOMODATIONS	7,533,159.00	215,439.00
			TOTAL CHARGES	31,015,167.37	530,012.27

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015342004097	11/24/15 - 11/29/15	12/14/15	0.00	6,249.00	0.00	0.00	0.00
614	2015342004432	11/02/15 - 11/06/15	12/14/15	0.00	6,249.00	0.00	6,141.00	0.00
614	2016006002187	12/26/15 - 12/29/15	01/11/16	0.00	5,466.00	0.00	0.00	0.00
614	2016057078166	01/18/16 - 01/26/16	03/07/16	0.00	5,684.00	0.00	0.00	0.00
614	2016133004902	04/03/16 - 04/29/16	05/23/16	0.00	5,973.00	0.00	0.00	0.00
614	2016138006618	03/20/16 - 04/14/16	05/23/16	0.00	5,466.00	0.00	0.00	0.00
615	2016145003424	05/06/16 - 05/16/16	05/30/16	0.00	2,070.00	0.00	0.00	0.00
614	2016196002311	06/27/16 - 07/06/16	07/18/16	0.00	5,970.00	0.00	0.00	0.00
614	2016233003645	06/20/16 - 06/28/16	08/29/16	0.00	5,740.00	0.00	0.00	0.00
614	2016280107864	08/17/16 - 09/16/16	10/10/16	0.00	6,275.00	0.00	0.00	0.00
614	9816302000033	05/14/16 - 05/21/16	11/07/16	0.00	5,740.00	0.00	0.00	0.00
615	2217019005375	06/24/16 - 07/24/16	01/23/17	0.00	4,075.00	0.00	0.00	0.00
614	2017026064912	06/10/16 - 06/13/16	01/30/17	0.00	6,565.00	0.00	0.00	0.00
614	2217031011164	08/26/16 - 08/31/16	02/06/17	0.00	6,565.00	0.00	0.00	0.00
TOTAL				0.00	78,087.00	0.00	6,141.00	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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	471,297.68	ADJUSTMENTS	0.00
COVERED CHARGES	448,067.54	CONTRACTUAL ALLOW	202,169.92
NON-COVERD CHARGES	23,230.14	TOTAL MEDICAID LIAB	245,897.62
		LESS: COB	245,897.62
		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	29		0	32,292.00		2,932.00
ROUTINE NURSERY	13		0	12,240.00		1,895.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	42		0	44,532.00		4,827.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	47		0	165,346.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	165,346.00		0.00
TOTAL ACCOMODATIONS	89		0	209,878.00		4,827.00

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,909.88	1,399.95	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	14,841.86	382.19	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	53,391.50	186.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,076.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,148.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,629.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,673.00	0.00	MRI SERVICES	28,142.00	0.00
IV THERAPY	2,585.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	28,251.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	31,911.00	10,590.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	16,737.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,729.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,601.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	249.00	0.00	INJECTABLE DRUGS	319.30	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	949.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	84.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	5,845.00
OTHER IMAGING SERVICE	2,374.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	646.00	0.00			
CARDIOLOGY	7,545.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,398.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	238,189.54	18,403.14
			TOTAL ACCOMODATIONS	209,878.00	4,827.00
			TOTAL CHARGES	448,067.54	23,230.14

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

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016069001297	10/05/15 - 10/14/15	03/14/16	0.00	5,845.00	0.00	57,793.83	0.00
TOTAL				0.00	5,845.00	0.00	57,793.83	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: 08/24/2017
Run Time: 03:23:16
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,233,248.02	ADJUSTMENTS	531,968.16
COVERED CHARGES	24,120,159.72	CONTRACTUAL ALLOW	20,645,980.74
NON-COVERD CHARGES	1,113,088.30	TOTAL MEDICAID LIAB	3,474,178.98
		LESS: COB	24,295.44
		LESS: COPAYMENT	7,780.11
		REIMBURSEMENT	3,442,103.43
		ALL OTHER	2,887,895.57
		FEE SCHEDULE-LAB	324,355.47
		INJECTABLE DRUGS	229,852.39

TOTAL NUMBER OF CLAIMS 8,403

HAMILTON MEDICAL CENTER
 1200 MEMORIAL DR
 DALTON,GA 30720-2529

PROVIDER NUMBER
 000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	550,245.92	5,804.30	OTHER LAB	516,795.00	1,535.00
MED/SURG SUPPLY	806,098.90	4,316.55	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	4,575.00	0.00
RADIOLOGY-DIAGNOSTIC	1,379,615.00	27,022.00	OTHER THERAPEUTIC SVC	0.00	503.00
CT SCAN	2,236,597.00	149,984.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	31,838.00	9,878.11	FEE SCHEDULE LAB	5,619,513.13	189,330.75
EKG/ECG	443,452.00	342.00	MRI SERVICES	942,479.00	91,074.00
IV THERAPY	1,616,088.00	13,866.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,519,572.55	137,603.45	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	11,569.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	224,642.00	70,330.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	142,844.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,056.00	0.00	CAST ROOM	603.00	0.00
EMERGENCY ROOM	3,562,590.09	12,203.66	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	125,723.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	796,096.52	29,512.55
RADIOLOGY THERAPEUTIC	750,683.00	219.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	43,451.00	21,117.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	5,286.07	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,659.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	107,902.00	0.00	TRAUMA RESPONSE	0.00	42,259.00
PSYCHIATRIC SERVICES	852.00	22,198.00	IMPL DEV CHARGE PATIENTS	94,681.61	40.86
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	711,860.00	150,957.00			
BLOOD	18,423.00	0.00			
BLOOD STORAGE & PRO.	11,956.00	836.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	262,979.00	44,916.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	727,508.00	66,127.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	387,581.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	470,290.00	12,168.00			
			TOTAL ANCILLARY	24,120,159.72	1,113,088.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	24,120,159.72	1,113,088.30

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

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	505,068.90	ADJUSTMENTS	0.00
COVERED CHARGES	417,631.36	CONTRACTUAL ALLOW	185,177.56
NON-COVERD CHARGES	87,437.54	TOTAL MEDICAID LIAB	232,453.80
		LESS: COB	232,378.84
		LESS: COPAYMENT	74.96
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 162

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,950.60	804.95	OTHER LAB	3,274.00	0.00
MED/SURG SUPPLY	26,239.35	120.59	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,334.00	709.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	27,197.00	20,952.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,672.00	1,360.00	FEE SCHEDULE LAB	107,969.29	3,780.00
EKG/ECG	3,150.00	0.00	MRI SERVICES	10,630.00	7,149.00
IV THERAPY	23,996.00	1,120.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	57,818.00	16,086.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,032.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,028.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,971.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	66,616.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,202.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	434.60	174.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	168.00	0.00	TRAUMA RESPONSE	0.00	2,185.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	397.52	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	26,823.00	32,623.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,378.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,351.00	374.00			
			TOTAL ANCILLARY	417,631.36	87,437.54
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	417,631.36	87,437.54

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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HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	555,164.85	ADJUSTMENTS	441.52
COVERED CHARGES	533,736.85	CONTRACTUAL ALLOW	511,584.61
NON-COVERD CHARGES	21,428.00	TOTAL MEDICAID LIAB	22,152.24
		LESS: COB	0.00
		LESS: COPAYMENT	726.41
		REIMBURSEMENT	21,425.83
		TOTAL NUMBER OF CLAIMS	396

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,470.30	0.00	OTHER LAB	2,382.00	0.00
MED/SURG SUPPLY	7,904.97	282.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,076.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,043.00	3,145.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	134,434.00	6,014.00
EKG/ECG	9,144.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	24,035.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,619.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	217.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,572.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	704.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	248,155.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,028.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	116.58	58.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	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	22,501.00	11,566.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	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	533,736.85	21,428.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	533,736.85	21,428.00

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

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	28,961.77	ADJUSTMENTS	0.00
COVERED CHARGES	25,953.77	CONTRACTUAL ALLOW	13,810.08
NON-COVERD CHARGES	3,008.00	TOTAL MEDICAID LIAB	12,143.69
		LESS: COB	12,134.69
		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

HAMILTON MEDICAL CENTER
 1200 MEMORIAL DR
 DALTON,GA 30720-2529

PROVIDER NUMBER
 000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	664.40	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	368.37	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,298.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,420.00	114.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	928.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	339.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,002.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	58.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,934.00	2,836.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	25,953.77	3,008.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,953.77	3,008.00

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

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,873,787.27	ADJUSTMENTS	89,448.82
COVERED CHARGES	3,790,043.09	CONTRACTUAL ALLOW	3,374,671.70
NON-COVERD CHARGES	83,744.18	TOTAL MEDICAID LIAB	415,371.39
		LESS: COB	0.00
		LESS: COPAYMENT	426.00
		REIMBURSEMENT	414,945.39

TOTAL NUMBER OF CLAIMS 75

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	40,526.38	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	130,657.66	1,452.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	64,182.00	4,390.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,180.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	98,591.50	4,128.00
EKG/ECG	13,320.00	1,368.00	MRI SERVICES	0.00	0.00
IV THERAPY	107,303.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	585,510.00	34,650.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,612.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,040.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,170.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	976.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,780,232.55	23,601.68
RADIOLOGY THERAPEUTIC	215,794.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	252.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	372,707.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,892.50
OTHER IMAGING SERVICE	960.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	3,626.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	363,137.00	7,636.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,892.00	0.00			
			TOTAL ANCILLARY	3,790,043.09	83,744.18
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,790,043.09	83,744.18

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: 08/24/2017
Run Time: 03:24:06
Page: 17

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5916147001124	04/21/16 - 04/21/16	05/30/16	0.00	2,892.50	0.00	0.00	0.00
TOTAL				0.00	2,892.50	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: 08/24/2017
Run Time: 03:24:09
Page: 18

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	10/01/15	THROUGH	09/30/16
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000943A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	288,150,253.22	ADJUSTMENTS	28,202,138.54
COVERED CHARGES	277,640,697.08	CONTRACTUAL ALLOW	189,897,411.75
NON-COVERD CHARGES	10,509,556.14	TOTAL MEDICAID LIAB	87,743,285.33
		LESS: COB	588,659.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	87,154,625.65

TOTAL NUMBER OF ADMISSIONS 3,049

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	14,284	133	18,868,083.50	6,399,024.00
ROUTINE NURSERY	611	0	1,483,946.50	27,512.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	14,895	133	20,352,030.00	6,426,536.00
SPECIAL CARE SERVICES				
CCU	1,999	0	8,681,110.50	0.00
ICU	0	0	0.00	0.00
NICU	2,724	0	15,852,330.00	0.00
PED ICU	3,851	0	16,995,543.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	8,574	0	41,528,983.50	0.00
TOTAL ACCOMODATIONS	23,469	133	61,881,013.50	6,426,536.00

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	54,069,061.39	109,130.80	OTHER LAB	852,444.00	8,088.00
MED/SURG SUPPLY	13,797,889.26	123,501.34	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	39,242,783.43	983,516.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,108,755.00	2,711.00	OTHER THERAPEUTIC SVC	45,102.00	136,431.00
CT SCAN	1,738,496.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,184,636.00	5,831.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	301,194.00	0.00	MRI SERVICES	1,482,541.00	0.00
IV THERAPY	49,954.50	5,451.50	PROFESSIONAL FEES	0.00	5,806.00
OPERATING ROOM	27,295,641.50	70,319.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	24,275,170.50	170,199.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,217,974.50	24,626.00	AMBULANCE	0.00	0.00
GI SERVICES	21,835.50	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,992,295.00	20,694.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,105,856.50	852.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,636,506.00	0.00	INJECTABLE DRUGS	67,765.00	0.00
RADIOLOGY THERAPEUTIC	209,451.00	3,056.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	608,383.50	2,673.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	549,631.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	74,841.50	210,473.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	963.50	48,618.00	TRAUMA RESPONSE	0.00	103,268.50
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	9,305,190.50	101,894.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	712,207.50	148,162.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,459,132.00	1,527,310.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	376,112.00	10,938.00			
AUDIOLOGY	67,932.50	0.00			
CARDIOLOGY	6,025,279.50	2,954.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,597,819.00	92,054.50			
ORGAN ACQUISITION	2,093,567.00	10,211.00			
TREATMENT/OBSERV. RM	193,271.50	154,250.00			
			TOTAL ANCILLARY	215,759,683.58	4,083,020.14
			TOTAL ACCOMODATIONS	61,881,013.50	6,426,536.00
			TOTAL CHARGES	277,640,697.08	10,509,556.14

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

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

Run Date: 08/24/2017
 Run Time: 02:24:44
 Page: 3

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,202,071.41	ADJUSTMENTS	0.00
COVERED CHARGES	8,910,802.41	CONTRACTUAL ALLOW	1,813,230.11
NON-COVERD CHARGES	291,269.00	TOTAL MEDICAID LIAB	7,097,572.30
		LESS: COB	7,097,572.30
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 118

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	486		16	610,988.00		239,692.50
ROUTINE NURSERY	48		0	126,061.50		1,086.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	534		16	737,049.50		240,778.50
SPECIAL CARE SERVICES						
CCU	14		0	60,753.00		0.00
ICU	0		0	0.00		0.00
NICU	55		0	318,615.00		0.00
PED ICU	190		0	842,745.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	259		0	1,222,113.00		0.00
TOTAL ACCOMODATIONS	793		16	1,959,162.50		240,778.50

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,952,660.25	0.00	OTHER LAB	31,892.50	0.00
MED/SURG SUPPLY	409,416.56	282.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	957,224.10	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	68,487.00	0.00	OTHER THERAPEUTIC SVC	446.50	6,313.50
CT SCAN	55,976.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	47,617.50	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	14,606.00	0.00	MRI SERVICES	39,586.00	0.00
IV THERAPY	1,233.50	0.00	PROFESSIONAL FEES	0.00	39,092.50
OPERATING ROOM	760,614.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	701,097.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	339,829.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,806.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	136,241.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	52,369.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	131,487.50	0.00	INJECTABLE DRUGS	1,530.00	0.00
RADIOLOGY THERAPEUTIC	17,906.50	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	19,813.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	15,842.50	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	100.50	1,026.50	TRAUMA RESPONSE	0.00	3,401.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	492,425.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,935.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	100,488.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	22,820.00	0.00			
AUDIOLOGY	1,560.50	0.00			
CARDIOLOGY	152,787.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	262,924.50	0.00			
ORGAN ACQUISITION	129,039.00	0.00			
TREATMENT/OBSERV. RM	15,877.00	375.00			
			TOTAL ANCILLARY	6,951,639.91	50,490.50
			TOTAL ACCOMODATIONS	1,959,162.50	240,778.50
			TOTAL CHARGES	8,910,802.41	291,269.00

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: 08/24/2017
Run Time: 02:24:49
Page: 5

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	75,039,185.87	ADJUSTMENTS	2,447,410.73
COVERED CHARGES	66,865,578.93	CONTRACTUAL ALLOW	50,520,556.86
NON-COVERD CHARGES	8,173,606.94	TOTAL MEDICAID LIAB	16,345,022.07
		LESS: COB	32,920.63
		LESS: COPAYMENT	273.00
		REIMBURSEMENT	16,311,828.44
		ALL OTHER	12,752,503.30
		FEE SCHEDULE-LAB	892,970.56
		INJECTABLE DRUGS	2,666,354.58

TOTAL NUMBER OF CLAIMS 20,144

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,310,015.75	21,247.50	OTHER LAB	635,660.00	7,102.00
MED/SURG SUPPLY	3,380,857.31	1,893.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	575.50	0.00
RADIOLOGY-DIAGNOSTIC	1,565,956.50	43,403.50	OTHER THERAPEUTIC SVC	0.00	4,481.50
CT SCAN	1,619,947.00	120,193.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	16,756.50	23,307.50	FEE SCHEDULE LAB	14,683,420.91	2,414,995.40
EKG/ECG	117,494.00	19,101.00	MRI SERVICES	3,562,738.50	388,865.00
IV THERAPY	1,207,230.00	37,115.50	PROFESSIONAL FEES	0.00	6,325.50
OPERATING ROOM	8,230,883.21	1,103,293.79	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	779,633.50	75,752.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,267,965.50	2,693.00	AMBULANCE	0.00	0.00
GI SERVICES	78,769.00	5,259.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,964,204.50	57,475.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,590,550.00	852.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	4,281.00	INJECTABLE DRUGS	6,589,254.75	2,003,525.75
RADIOLOGY THERAPEUTIC	313,557.50	7,755.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,461.50	3,423.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	365,680.50	25,137.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,411,455.50	229,814.00	TRAUMA RESPONSE	0.00	147,896.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	306,497.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,020,632.00	153,388.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,144,527.50	9,961.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	462,918.00	126,923.50			
AUDIOLOGY	119,452.50	9,194.50			
CARDIOLOGY	1,714,274.00	816,642.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,934,858.00	12,978.00			
ORGAN ACQUISITION	0.00	109,072.00			
TREATMENT/OBSERV. RM	1,461,352.50	180,259.00			
			TOTAL ANCILLARY	66,865,578.93	8,173,606.94
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	66,865,578.93	8,173,606.94

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: 08/24/2017
Run Time: 02:26:18
Page: 7

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,381,239.18	ADJUSTMENTS	0.00
COVERED CHARGES	1,910,618.43	CONTRACTUAL ALLOW	302,827.92
NON-COVERD CHARGES	470,620.75	TOTAL MEDICAID LIAB	1,607,790.51
		LESS: COB	1,607,790.51
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 436

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39,540.00	1,525.00	OTHER LAB	16,857.00	0.00
MED/SURG SUPPLY	143,321.93	359.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	24,374.50	0.00	OTHER THERAPEUTIC SVC	0.00	348.50
CT SCAN	15,283.50	10,307.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	733.50	FEE SCHEDULE LAB	262,897.00	46,569.50
EKG/ECG	3,970.00	0.00	MRI SERVICES	200,359.50	35,223.50
IV THERAPY	5,253.00	1,038.00	PROFESSIONAL FEES	0.00	11,355.50
OPERATING ROOM	319,109.50	123,266.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	24,520.50	5,649.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	302,848.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,106.50	903.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	64,124.50	151.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	85,179.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	162,935.50	103,942.25
RADIOLOGY THERAPEUTIC	43,323.00	4,582.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,237.50	1,268.00	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	22,910.50	7,246.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	26,414.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	30,630.50	3,156.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,466.00	1,181.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	982.50	184.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	22,828.50	107,862.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	56,430.00	0.00			
ORGAN ACQUISITION	0.00	3,769.50			
TREATMENT/OBSERV. RM	25,715.50	0.00			
			TOTAL ANCILLARY	1,910,618.43	470,620.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,910,618.43	470,620.75

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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,138,038.75	ADJUSTMENTS	1,062.86
COVERED CHARGES	1,974,595.75	CONTRACTUAL ALLOW	1,887,273.41
NON-COVERD CHARGES	163,443.00	TOTAL MEDICAID LIAB	87,322.34
		LESS: COB	0.00
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	87,289.34
		TOTAL NUMBER OF CLAIMS	1,561

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	52,073.75	0.00	OTHER LAB	71,145.50	0.00
MED/SURG SUPPLY	38,020.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	89,848.50	250.50	OTHER THERAPEUTIC SVC	0.00	518.00
CT SCAN	11,020.50	19,541.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	383,035.00	74,897.00
EKG/ECG	10,850.00	0.00	MRI SERVICES	7,091.00	1,627.50
IV THERAPY	1,047.00	692.00	PROFESSIONAL FEES	0.00	1,949.00
OPERATING ROOM	41,552.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,466.00	2,741.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,444.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,124,056.50	7,309.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,515.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	53,326.50	39,030.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,618.00	168.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	621.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	31,122.00	10,623.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,073.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	2,284.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	8,856.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,812.50	1,812.50			
			TOTAL ANCILLARY	1,974,595.75	163,443.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,974,595.75	163,443.00

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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Run Time: 02:26:32
Page: 11

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	73,064.00	ADJUSTMENTS	0.00
COVERED CHARGES	67,664.75	CONTRACTUAL ALLOW	51,684.78
NON-COVERD CHARGES	5,399.25	TOTAL MEDICAID LIAB	15,979.97
		LESS: COB	15,979.97
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 13

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,276.75	0.00	OTHER LAB	2,560.50	0.00
MED/SURG SUPPLY	3,639.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,600.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,766.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	488.00	0.00	FEE SCHEDULE LAB	6,444.50	1,958.50
EKG/ECG	0.00	310.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	1,352.50
OPERATING ROOM	10,467.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,423.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,001.50	609.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,278.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,472.00	555.75
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	2,810.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	613.50			
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	3,437.50	0.00			
			TOTAL ANCILLARY	67,664.75	5,399.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	67,664.75	5,399.25

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

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

Run Date: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,329,853.15	ADJUSTMENTS	296,137.05
COVERED CHARGES	12,318,083.15	CONTRACTUAL ALLOW	9,924,041.85
NON-COVERD CHARGES	2,011,770.00	TOTAL MEDICAID LIAB	2,394,041.30
		LESS: COB	42,636.32
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	2,351,401.98

TOTAL NUMBER OF CLAIMS 263

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	94,939.50	61.50	OTHER LAB	7,359.00	0.00
MED/SURG SUPPLY	2,194,256.96	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	482,284.50	104,268.00	OTHER THERAPEUTIC SVC	0.00	175.00
CT SCAN	12,681.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	4,653.50	FEE SCHEDULE LAB	673,844.94	278,514.00
EKG/ECG	1,753.50	14,570.00	MRI SERVICES	29,440.00	20,759.50
IV THERAPY	44,517.50	7,969.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,757,520.00	165,399.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	21,163.50	3,299.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,384,770.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	19,680.50	2,106.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,491.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	182,830.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,466,938.25	103,769.00
RADIOLOGY THERAPEUTIC	13,336.50	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	542.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	2,880.50	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	6,388.00	2,866.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,044,412.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,065.50	29,003.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,602.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	14,477.50	3,960.50			
AUDIOLOGY	390.50	0.00			
CARDIOLOGY	2,548,386.00	1,251,785.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	119,054.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	160,500.00	15,187.50			
			TOTAL ANCILLARY	12,318,083.15	2,011,770.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,318,083.15	2,011,770.00

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: 08/24/2017
Run Time: 02:26:43
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	665,412.00	ADJUSTMENTS	0.00
COVERED CHARGES	582,424.75	CONTRACTUAL ALLOW	-11,964.28
NON-COVERD CHARGES	82,987.25	TOTAL MEDICAID LIAB	594,389.03
		LESS: COB	594,389.03
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	14

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,161.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	92,935.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	23,801.50	1,332.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	32,376.50	10,878.50
EKG/ECG	0.00	620.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,420.00	1,038.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	119,195.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	354.00	30.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	95,238.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	16,729.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	35,312.75	5,479.75
RADIOLOGY THERAPEUTIC	1,096.50	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	9,910.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	613.50			
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	141,332.00	62,995.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,562.50	0.00			
			TOTAL ANCILLARY	582,424.75	82,987.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	582,424.75	82,987.25

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	632,213.10	ADJUSTMENTS	40,753.46
COVERED CHARGES	632,213.10	CONTRACTUAL ALLOW	338,749.23
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	293,463.87
		LESS: COB	6,869.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	286,594.46

TOTAL NUMBER OF ADMISSIONS 40

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	62		0	72,850.00		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	72,850.00		0.00
SPECIAL CARE SERVICES						
CCU	41		0	71,750.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	41		0	71,750.00		0.00
TOTAL ACCOMODATIONS	103		0	144,600.00		0.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	50,387.03	0.00	OTHER LAB	1,414.00	0.00
MED/SURG SUPPLY	34,733.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	114,430.00	0.00	EDUCATION & TRAINING	335.00	0.00
RADIOLOGY-DIAGNOSTIC	12,424.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	32,175.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,020.19	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,989.00	0.00	MRI SERVICES	7,070.00	0.00
IV THERAPY	18,900.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,948.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	80,261.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	67,382.00	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	17,541.18	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	994.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,120.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,860.90	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,782.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,144.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,435.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,791.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,052.00	0.00			
			TOTAL ANCILLARY	487,613.10	0.00
			TOTAL ACCOMODATIONS	144,600.00	0.00
			TOTAL CHARGES	632,213.10	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

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 07/01/15 THROUGH 06/30/16
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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,306,444.65	ADJUSTMENTS	130,119.31
COVERED CHARGES	5,146,023.38	CONTRACTUAL ALLOW	4,130,681.80
NON-COVERD CHARGES	160,421.27	TOTAL MEDICAID LIAB	1,015,341.58
		LESS: COB	126.37
		LESS: COPAYMENT	2,469.00
		REIMBURSEMENT	1,012,746.21
		ALL OTHER	928,304.55
		FEE SCHEDULE-LAB	73,383.34
		INJECTABLE DRUGS	11,058.32
		TOTAL NUMBER OF CLAIMS	2,041

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	149,483.87	0.00	OTHER LAB	34,711.00	0.00
MED/SURG SUPPLY	27,732.03	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	4,811.00	EDUCATION & TRAINING	0.00	315.00
RADIOLOGY-DIAGNOSTIC	264,461.00	4,390.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	955,239.00	51,437.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	122,321.00	9,440.00	FEE SCHEDULE LAB	809,571.00	14,485.00
EKG/ECG	56,153.00	1,446.00	MRI SERVICES	202,062.00	7,408.00
IV THERAPY	389,335.00	13,660.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	231,241.00	11,443.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	85,018.00	1,800.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	72,829.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	100,191.00	6,128.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,253,431.00	6,087.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,906.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	77,770.24	15,922.27
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	2,030.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	21,349.24	0.00
LITHOTRIPSY	93,051.00	1,785.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	77,543.00	3,444.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,988.00	800.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	38,280.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	16,815.00	3,590.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	50,542.00	0.00			
			TOTAL ANCILLARY	5,146,023.38	160,421.27
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,146,023.38	160,421.27

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

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	38,584.99	ADJUSTMENTS	0.00
COVERED CHARGES	24,614.99	CONTRACTUAL ALLOW	7,116.12
NON-COVERD CHARGES	13,970.00	TOTAL MEDICAID LIAB	17,498.87
		LESS: COB	17,489.87
		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

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	702.24	201.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	975.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	10,923.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,338.00	470.00
EKG/ECG	241.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,625.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,265.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	468.75	375.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,000.00	2,001.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	24,614.99	13,970.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	24,614.99	13,970.00

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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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	255,079.89	ADJUSTMENTS	391.00
COVERED CHARGES	250,922.98	CONTRACTUAL ALLOW	241,272.98
NON-COVERD CHARGES	4,156.91	TOTAL MEDICAID LIAB	9,650.00
		LESS: COB	0.00
		LESS: COPAYMENT	354.17
		REIMBURSEMENT	9,295.83
		TOTAL NUMBER OF CLAIMS	193

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,266.83	0.00	OTHER LAB	1,118.00	0.00
MED/SURG SUPPLY	488.92	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	255.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,440.00	300.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	30,917.00	1,823.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	41,283.00	393.00
EKG/ECG	964.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	16,280.00	795.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,235.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	130,359.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,537.23	140.91
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,034.00	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	0.00	0.00			
			TOTAL ANCILLARY	250,922.98	4,156.91
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	250,922.98	4,156.91

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,657.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,657.00	CONTRACTUAL ALLOW	695.11
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	961.89
		LESS: COB	961.89
		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
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 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	300.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	99.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,258.00	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,657.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,657.00	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

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,039.66	ADJUSTMENTS	4,862.89
COVERED CHARGES	29,018.66	CONTRACTUAL ALLOW	24,155.77
NON-COVERD CHARGES	21.00	TOTAL MEDICAID LIAB	4,862.89
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,862.89

TOTAL NUMBER OF CLAIMS 1

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,436.76	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	4,550.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	845.00	21.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,385.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,705.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,674.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,418.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	342.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	843.90	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	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	819.00	0.00			
			TOTAL ANCILLARY	29,018.66	21.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	29,018.66	21.00

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

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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,190,258.16	ADJUSTMENTS	805,232.84
COVERED CHARGES	24,328,280.67	CONTRACTUAL ALLOW	14,346,159.28
NON-COVERD CHARGES	1,861,977.49	TOTAL MEDICAID LIAB	9,982,121.39
		LESS: COB	54,156.81
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,927,964.58

TOTAL NUMBER OF ADMISSIONS 1,379

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	4,985		3	3,927,108.00		1,737,292.00
ROUTINE NURSERY	450		0	306,085.00		16,115.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5,435		3	4,233,193.00		1,753,407.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,036		0	2,106,000.00		0.00
NICU	16		0	40,000.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,052		0	2,146,000.00		0.00
TOTAL ACCOMODATIONS	6,487		3	6,379,193.00		1,753,407.00

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,953,521.27	30,788.38	OTHER LAB	76,134.02	0.00
MED/SURG SUPPLY	548,557.35	4,011.87	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,109,976.68	2,499.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	430,258.77	769.79	OTHER THERAPEUTIC SVC	0.00	99.60
CT SCAN	623,000.00	16,326.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	323,677.79	12,164.04	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	420,180.00	894.00	MRI SERVICES	149,000.00	0.00
IV THERAPY	28,692.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,760,408.84	11,160.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,036,740.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,520,497.70	17,751.20	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	399,150.00	2,700.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,570,035.50	1,002.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	222,438.00	954.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	75,590.79	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	2,824.80	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	65,530.83	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	321,598.50	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,331.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	409,679.48	250.29
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,000.00
OTHER IMAGING SERVICE	145,015.06	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	186,140.03	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	67,388.73	1,912.32			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,124,865.61	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	225,087.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	147,767.92	3,288.00			
			TOTAL ANCILLARY	17,949,087.67	108,570.49
			TOTAL ACCOMODATIONS	6,379,193.00	1,753,407.00
			TOTAL CHARGES	24,328,280.67	1,861,977.49

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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2316146000032	04/12/16 - 04/15/16	07/04/16	0.00	1,000.00	0.00	805.68	0.00
615	2317158000243	12/28/16 - 01/09/17	07/10/17	0.00	1,000.00	0.00	1,682.67	0.00
TOTAL				0.00	2,000.00	0.00	2,488.35	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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	994,568.65	ADJUSTMENTS	0.00
COVERED CHARGES	893,196.79	CONTRACTUAL ALLOW	535,650.28
NON-COVERD CHARGES	101,371.86	TOTAL MEDICAID LIAB	357,546.51
		LESS: COB	357,546.51
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 25

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	107		0	73,413.00		98,437.00
ROUTINE NURSERY	9		0	5,751.00		549.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	116		0	79,164.00		98,986.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	67		0	167,500.00		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	67		0	167,500.00		0.00
TOTAL ACCOMODATIONS	183		0	246,664.00		98,986.00

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	120,505.87	0.00	OTHER LAB	632.64	0.00
MED/SURG SUPPLY	16,647.94	163.36	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	92,114.97	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,988.94	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,250.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,199.42	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,874.00	0.00	MRI SERVICES	1,000.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	39,352.78	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	61,978.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	106,859.85	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,300.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,317.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,016.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	519.36	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	51,436.50	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	9,708.86	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,000.00
OTHER IMAGING SERVICE	4,520.84	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	18,998.59	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,809.12	1,222.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	24,294.85	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	28,140.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,066.26	0.00			
			TOTAL ANCILLARY	646,532.79	2,385.86
			TOTAL ACCOMODATIONS	246,664.00	98,986.00
			TOTAL CHARGES	893,196.79	101,371.86

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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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2017110060761	12/09/16 - 02/14/17	04/24/17	0.00	1,000.00	0.00	177,677.05	0.00
TOTAL				0.00	1,000.00	0.00	177,677.05	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: 08/24/2017
Run Time: 03:25:22
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,332,923.52	ADJUSTMENTS	392,070.59
COVERED CHARGES	16,366,865.56	CONTRACTUAL ALLOW	12,580,402.89
NON-COVERD CHARGES	966,057.96	TOTAL MEDICAID LIAB	3,786,462.67
		LESS: COB	31,490.36
		LESS: COPAYMENT	9,138.62
		REIMBURSEMENT	3,745,833.69
		ALL OTHER	3,177,067.92
		FEE SCHEDULE-LAB	319,932.82
		INJECTABLE DRUGS	248,832.95
		TOTAL NUMBER OF CLAIMS	7,612

SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

HOUSTON MEDICAL CENTER
 1601 WATSON BLVD
 WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
 000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	96,434.05	11,144.76	OTHER LAB	201,653.62	0.00
MED/SURG SUPPLY	167,816.13	10,093.87	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	4,159.00	0.00
RADIOLOGY-DIAGNOSTIC	555,650.91	2,082.87	OTHER THERAPEUTIC SVC	0.00	866.70
CT SCAN	746,698.00	52,500.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	53,316.78	36,564.29	FEE SCHEDULE LAB	1,372,842.49	83,123.06
EKG/ECG	425,838.00	1,192.00	MRI SERVICES	116,000.00	14,000.00
IV THERAPY	1,044,622.50	5,565.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,516,849.69	186,636.64	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	729.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	100,613.65	25,764.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	240,750.00	3,600.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,855,585.45	3,953.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	407,754.00	5,574.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	760,309.48	132,773.44
RADIOLOGY THERAPEUTIC	12,855.54	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	44,284.17	17,534.67	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,676.83	3,458.43	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	141,693.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	13,902.19	7,717.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	75,682.58	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,000.00
OTHER IMAGING SERVICE	387,614.65	55,116.58			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	36,178.35	5,041.52			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	114,195.98	3,014.20			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	583,008.01	143,595.93			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	33,046.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	391,798.01	12,452.50			
			TOTAL ANCILLARY	16,366,865.56	966,057.96
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,366,865.56	966,057.96

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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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5917040002349	12/15/16 - 12/15/16	02/13/17	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

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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	417,332.28	ADJUSTMENTS	0.00
COVERED CHARGES	328,733.78	CONTRACTUAL ALLOW	160,969.62
NON-COVERD CHARGES	88,598.50	TOTAL MEDICAID LIAB	167,764.16
		LESS: COB	167,579.06
		LESS: COPAYMENT	185.10
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 169

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,917.85	0.00	OTHER LAB	5,444.62	0.00
MED/SURG SUPPLY	10,143.13	3,036.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	254.00	0.00
RADIOLOGY-DIAGNOSTIC	5,688.85	165.33	OTHER THERAPEUTIC SVC	0.00	697.20
CT SCAN	10,750.00	3,750.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,439.28	867.12	FEE SCHEDULE LAB	24,257.91	3,072.42
EKG/ECG	3,576.00	0.00	MRI SERVICES	1,000.00	0.00
IV THERAPY	24,054.30	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	39,898.80	22,604.38	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,343.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,413.40	297.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,600.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	122,241.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	16,206.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,695.12	30,533.87
RADIOLOGY THERAPEUTIC	312.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	249.27	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	186.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,843.61	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,601.67	2,505.72			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	904.56	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,333.39	20,633.39			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,233.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,581.79	0.00			
			TOTAL ANCILLARY	328,733.78	88,598.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	328,733.78	88,598.50

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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	401,152.31	ADJUSTMENTS	52.94
COVERED CHARGES	397,744.72	CONTRACTUAL ALLOW	381,466.18
NON-COVERD CHARGES	3,407.59	TOTAL MEDICAID LIAB	16,278.54
		LESS: COB	43.24
		LESS: COPAYMENT	449.23
		REIMBURSEMENT	15,786.07
		TOTAL NUMBER OF CLAIMS	291

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	255.16	0.00	OTHER LAB	417.62	0.00
MED/SURG SUPPLY	30.66	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,980.73	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,250.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	486.60	1,026.00	FEE SCHEDULE LAB	17,046.51	423.00
EKG/ECG	3,874.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	11,914.50	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	592.50	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	339,961.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,176.86	739.97
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	93.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,758.58	417.62			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	708.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	397,744.72	3,407.59
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	397,744.72	3,407.59

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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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	54,187.93	ADJUSTMENTS	0.00
COVERED CHARGES	51,896.12	CONTRACTUAL ALLOW	36,932.84
NON-COVERD CHARGES	2,291.81	TOTAL MEDICAID LIAB	14,963.28
		LESS: COB	14,942.28
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	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

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	49.53	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,265.78	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,000.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,942.17	99.00
EKG/ECG	298.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,086.50	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	39,500.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	83.66	104.71
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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,670.48	2,088.10			
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	51,896.12	2,291.81
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	51,896.12	2,291.81

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,236,678.49	ADJUSTMENTS	27,705.24
COVERED CHARGES	1,128,367.71	CONTRACTUAL ALLOW	896,872.26
NON-COVERD CHARGES	108,310.78	TOTAL MEDICAID LIAB	231,495.45
		LESS: COB	0.00
		LESS: COPAYMENT	259.86
		REIMBURSEMENT	231,235.59

TOTAL NUMBER OF CLAIMS 42

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,065.08	0.00	OTHER LAB	835.24	0.00
MED/SURG SUPPLY	56,499.18	3,002.49	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,030.11	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,000.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	16,710.33	652.77
EKG/ECG	11,920.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	35,882.10	666.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	354,280.48	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,500.00	948.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	48,600.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	27,570.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	47,310.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	240,175.23	13,317.72
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	14,720.59	77,642.48
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	417.62	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	3,014.20			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	234,785.00	9,067.12			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	22,066.75	0.00			
			TOTAL ANCILLARY	1,128,367.71	108,310.78
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,128,367.71	108,310.78

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

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,946.08	ADJUSTMENTS	0.00
COVERED CHARGES	29,714.37	CONTRACTUAL ALLOW	21,166.88
NON-COVERD CHARGES	231.71	TOTAL MEDICAID LIAB	8,547.49
		LESS: COB	8,538.49
		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

Run Date: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,863.78	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	165.33	0.00	OTHER THERAPEUTIC SVC	0.00	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	18,600.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,500.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,944.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	156.01	231.71
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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,545.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	892.50	0.00			
			TOTAL ANCILLARY	29,714.37	231.71
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	29,714.37	231.71

** 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: 08/24/2017
 Run Time: 03:27:02
 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 12/01/15 THROUGH 11/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,710,421.05	ADJUSTMENTS	84,582.70
COVERED CHARGES	1,621,811.49	CONTRACTUAL ALLOW	864,711.35
NON-COVERD CHARGES	88,609.56	TOTAL MEDICAID LIAB	757,100.14
		LESS: COB	2,499.49
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	754,600.65

TOTAL NUMBER OF ADMISSIONS 209

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	345		0	172,025.00		58,100.00
ROUTINE NURSERY	163		0	81,500.00		14,695.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	508		0	253,525.00		72,795.00
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	508		0	253,525.00		72,795.00

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 12/01/15 THROUGH 11/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	150,664.10	0.00	OTHER LAB	1,675.20	0.00
MED/SURG SUPPLY	143,412.03	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	120,414.29	0.00	EDUCATION & TRAINING	1,781.20	0.00
RADIOLOGY-DIAGNOSTIC	12,650.40	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,887.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,668.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	530,963.00	1,377.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	142,215.60	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	62,411.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	47,263.80	0.00	SPECIAL SERVICES	0.00	406.00
RECOVERY ROOM	29,855.20	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	16,308.23	0.00	INJECTABLE DRUGS	55,072.24	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	23,271.40	0.00			
BLOOD	0.00	6,210.36			
BLOOD STORAGE & PRO.	0.00	3,112.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	4,709.20			
CARDIOLOGY	7,503.80	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	270.00	0.00			
			TOTAL ANCILLARY	1,368,286.49	15,814.56
			TOTAL ACCOMODATIONS	253,525.00	72,795.00
			TOTAL CHARGES	1,621,811.49	88,609.56

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 12/01/15 THROUGH 11/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	51,184.71	ADJUSTMENTS	0.00
COVERED CHARGES	48,178.71	CONTRACTUAL ALLOW	21,021.28
NON-COVERD CHARGES	3,006.00	TOTAL MEDICAID LIAB	27,157.43
		LESS: COB	27,157.43
		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	5,000.00		2,450.00
ROUTINE NURSERY	2		0	1,000.00		90.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	12		0	6,000.00		2,540.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	12		0	6,000.00		2,540.00

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 12/01/15 THROUGH 11/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,101.06	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,222.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,997.33	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	18,102.00	405.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,631.60	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	412.80	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,006.60	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,225.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	754.27	0.00	INJECTABLE DRUGS	724.95	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	61.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	42,178.71	466.00
			TOTAL ACCOMODATIONS	6,000.00	2,540.00
			TOTAL CHARGES	48,178.71	3,006.00

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: 08/24/2017
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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 12/01/15 THROUGH 11/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,952,286.98	ADJUSTMENTS	73,584.40
COVERED CHARGES	1,768,115.86	CONTRACTUAL ALLOW	1,317,028.44
NON-COVERD CHARGES	184,171.12	TOTAL MEDICAID LIAB	451,087.42
		LESS: COB	7,006.19
		LESS: COPAYMENT	492.00
		REIMBURSEMENT	443,589.23
		ALL OTHER	390,959.97
		FEE SCHEDULE-LAB	48,909.34
		INJECTABLE DRUGS	3,719.92

TOTAL NUMBER OF CLAIMS 905

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 12/01/15 THROUGH 11/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	108,501.79	0.00	OTHER LAB	2,478.00	0.00
MED/SURG SUPPLY	47,893.29	13.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	40.64	EDUCATION & TRAINING	0.00	1,927.20
RADIOLOGY-DIAGNOSTIC	79,385.93	1,058.40	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	81,727.60	36,783.40	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	306,865.40	7,354.02
EKG/ECG	18,192.35	1,080.00	MRI SERVICES	0.00	0.00
IV THERAPY	58,666.40	4,495.20	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	508,078.00	92,196.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	27,061.03	10,875.80	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	38,789.60	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	255,930.94	946.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	34,088.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,699.05	230.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	11,604.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	113.68
OTHER IMAGING SERVICE	39,632.40	11,101.80			
BLOOD	0.00	674.98			
BLOOD STORAGE & PRO.	0.00	410.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,269.40	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	49,221.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	88,635.28	3,267.00			
			TOTAL ANCILLARY	1,768,115.86	184,171.12
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,768,115.86	184,171.12

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: 08/24/2017
Run Time: 03:27:05
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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 12/01/15 THROUGH 11/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
8361	2216341008324	11/14/16 - 11/15/16	12/12/16	0.00	56.84	0.00	0.00	0.00
8361	2216344011178	11/21/16 - 11/21/16	12/12/16	0.00	56.84	0.00	0.00	0.00
TOTAL				0.00	113.68	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: 08/24/2017
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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 12/01/15 THROUGH 11/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	52,714.04	ADJUSTMENTS	0.00
COVERED CHARGES	50,490.09	CONTRACTUAL ALLOW	27,372.61
NON-COVERD CHARGES	2,223.95	TOTAL MEDICAID LIAB	23,117.48
		LESS: COB	23,115.10
		LESS: COPAYMENT	2.38
		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

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 12/01/15 THROUGH 11/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,137.80	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	683.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	992.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,195.39	266.75
EKG/ECG	240.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,291.20	216.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	31,954.00	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	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,014.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,562.20	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	77.50	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	1,066.20	649.20			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,106.80	100.00			
			TOTAL ANCILLARY	50,490.09	2,223.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	50,490.09	2,223.95

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: 08/24/2017
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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 12/01/15 THROUGH 11/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	105,362.14	ADJUSTMENTS	161.82
COVERED CHARGES	103,524.34	CONTRACTUAL ALLOW	97,315.00
NON-COVERD CHARGES	1,837.80	TOTAL MEDICAID LIAB	6,209.34
		LESS: COB	0.00
		LESS: COPAYMENT	198.00
		REIMBURSEMENT	6,011.34
		TOTAL NUMBER OF CLAIMS	111

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 12/01/15 THROUGH 11/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,240.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	222.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,619.60	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,580.60	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,731.49	271.00
EKG/ECG	855.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,812.80	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	6,043.20	608.80	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	55,914.13	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	443.97	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	917.40	958.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,142.60	0.00			
			TOTAL ANCILLARY	103,524.34	1,837.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	103,524.34	1,837.80

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: 08/24/2017
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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 12/01/15 THROUGH 11/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	919.63	ADJUSTMENTS	0.00
COVERED CHARGES	919.63	CONTRACTUAL ALLOW	747.47
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	172.16
		LESS: COB	172.16
		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: 08/24/2017
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

IRWIN COUNTY HOSPITAL
 710 N IRWIN AVE
 OCILLA,GA 31774-5011

PROVIDER NUMBER
 000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 12/01/15 THROUGH 11/30/16
 ADMISSION DATES 00/00/00 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	57.23	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	118.80	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	743.60	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	919.63	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	919.63	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

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 12/01/15 THROUGH 11/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	189,804.57	ADJUSTMENTS	11,505.98
COVERED CHARGES	184,268.38	CONTRACTUAL ALLOW	138,232.46
NON-COVERD CHARGES	5,536.19	TOTAL MEDICAID LIAB	46,035.92
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	46,023.92
		TOTAL NUMBER OF CLAIMS	8

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 12/01/15 THROUGH 11/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,766.30	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	20,123.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	73.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,337.20	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,225.48	867.01
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,216.00	324.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	128,499.80	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	64.80	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,053.60	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,013.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	64.80	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,334.40	0.00			
BLOOD	0.00	674.98			
BLOOD STORAGE & PRO.	0.00	110.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,907.20	150.00			
			TOTAL ANCILLARY	184,268.38	5,536.19
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	184,268.38	5,536.19

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: 08/24/2017
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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	12/01/15	THROUGH	11/30/16
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: 08/24/2017
 Run Time: 03:27:25
 Page: 1

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,223.80	ADJUSTMENTS	0.00
COVERED CHARGES	18,413.80	CONTRACTUAL ALLOW	8,063.81
NON-COVERD CHARGES	810.00	TOTAL MEDICAID LIAB	10,349.99
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	10,349.99

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	8		0	2,926.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	8		0	2,926.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	8		0	2,926.00		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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,278.53	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	340.11	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,103.47	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	314.37	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,578.59	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	255.01	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	558.88	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	58.84	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	810.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	15,487.80	810.00
			TOTAL ACCOMODATIONS	2,926.00	0.00
			TOTAL CHARGES	18,413.80	810.00

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

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

Run Date: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
58	2216053008767	11/25/15 - 11/30/15	02/29/16	0.00	810.00	0.00	0.00	0.00
TOTAL				0.00	810.00	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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
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: 08/24/2017
Run Time: 03:27:25
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	343,028.94	ADJUSTMENTS	8,702.63
COVERED CHARGES	331,566.61	CONTRACTUAL ALLOW	154,944.94
NON-COVERD CHARGES	11,462.33	TOTAL MEDICAID LIAB	176,621.67
		LESS: COB	137.66
		LESS: COPAYMENT	855.00
		REIMBURSEMENT	175,629.01
		ALL OTHER	158,091.52
		FEE SCHEDULE-LAB	15,358.42
		INJECTABLE DRUGS	2,179.07

TOTAL NUMBER OF CLAIMS 663

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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,977.81	22.88	OTHER LAB	581.52	0.00
MED/SURG SUPPLY	4,856.73	118.21	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	37.52	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,482.59	125.77	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	60,342.02	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,966.98	2,234.36	FEE SCHEDULE LAB	112,945.66	5,204.37
EKG/ECG	3,768.73	201.94	MRI SERVICES	10,385.47	0.00
IV THERAPY	8,480.69	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	455.22	42.65	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	76,958.19	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,716.66	2,178.31
RADIOLOGY THERAPEUTIC	0.00	60.80	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	294.90	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,820.65	278.72	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,345.88	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	978.14	956.80			
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	364.57	0.00			
			TOTAL ANCILLARY	331,566.61	11,462.33
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	331,566.61	11,462.33

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

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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	10/01/15	THROUGH	09/30/16
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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JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,630.44	ADJUSTMENTS	0.00
COVERED CHARGES	9,371.75	CONTRACTUAL ALLOW	7,721.75
NON-COVERD CHARGES	258.69	TOTAL MEDICAID LIAB	1,650.00
		LESS: COB	0.00
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	1,614.00
		TOTAL NUMBER OF CLAIMS	33

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

JASPER MEMORIAL HOSP
 898 COLLEGE ST
 MONTICELLO,GA 31064-1258

PROVIDER NUMBER
 000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8.59	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	417.66	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,459.12	52.04
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,103.75	206.65	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	382.63	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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,371.75	258.69
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,371.75	258.69

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: 08/24/2017
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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	10/01/15	THROUGH	09/30/16
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	10/01/15	THROUGH	09/30/16
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

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/15	THROUGH	09/30/16
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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	575,586.95	ADJUSTMENTS	5,447.42
COVERED CHARGES	566,263.95	CONTRACTUAL ALLOW	315,868.96
NON-COVERD CHARGES	9,323.00	TOTAL MEDICAID LIAB	250,394.99
		LESS: COB	619.64
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	249,775.35

TOTAL NUMBER OF ADMISSIONS 47

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	144		0	64,800.00		7,550.00
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	144		0	64,800.00		7,550.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	17		0	17,000.00		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	17		0	17,000.00		0.00
TOTAL ACCOMODATIONS	161		0	81,800.00		7,550.00

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

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

Run Date: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	145,297.95	0.00	OTHER LAB	426.00	0.00
MED/SURG SUPPLY	77,135.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	104,322.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,715.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	61,024.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,268.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	1,678.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	38,943.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,238.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	25,202.00	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	4,487.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,005.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	750.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,156.00	95.00			
			TOTAL ANCILLARY	484,463.95	1,773.00
			TOTAL ACCOMODATIONS	81,800.00	7,550.00
			TOTAL CHARGES	566,263.95	9,323.00

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

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

Run Date: 08/24/2017
Run Time: 03:27:41
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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 10/01/15 THROUGH 09/30/16
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: 08/24/2017
Run Time: 03:27:41
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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,177,244.60	ADJUSTMENTS	3,265.96
COVERED CHARGES	1,057,926.70	CONTRACTUAL ALLOW	759,405.13
NON-COVERD CHARGES	119,317.90	TOTAL MEDICAID LIAB	298,521.57
		LESS: COB	60.00
		LESS: COPAYMENT	1,386.00
		REIMBURSEMENT	297,075.57
		ALL OTHER	263,062.27
		FEE SCHEDULE-LAB	31,673.07
		INJECTABLE DRUGS	2,340.23
		TOTAL NUMBER OF CLAIMS	1,198

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,833.35	5,654.50	OTHER LAB	33,953.00	0.00
MED/SURG SUPPLY	74,262.00	157.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	92,247.00	4,170.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	205,671.00	9,406.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	305,753.00	6,694.00
EKG/ECG	13,130.00	0.00	MRI SERVICES	50,820.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,925.00	1,678.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	18,305.00	6,820.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	20,348.00	2,476.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	140,998.00	30,327.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,295.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	28,665.35	31,117.40
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	4,400.00
OTHER IMAGING SERVICE	32,725.00	2,704.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	460.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,000.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	536.00	13,714.00			
			TOTAL ANCILLARY	1,057,926.70	119,317.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,057,926.70	119,317.90

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: 08/24/2017
Run Time: 03:27:41
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016259006660	09/09/16 - 09/09/16	09/19/16	0.00	4,400.00	0.00	0.00	0.00
TOTAL				0.00	4,400.00	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: 08/24/2017
Run Time: 03:27:48
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	31,544.00	ADJUSTMENTS	0.00
COVERED CHARGES	17,713.00	CONTRACTUAL ALLOW	803.13
NON-COVERD CHARGES	13,831.00	TOTAL MEDICAID LIAB	16,909.87
		LESS: COB	16,819.87
		LESS: COPAYMENT	90.00
		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

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,647.00	362.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,645.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,075.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,788.00	2,806.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,120.00	102.00
EKG/ECG	112.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	150.00	75.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,150.00	1,144.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	5,396.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,267.00	392.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	626.00	2,520.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	133.00	1,034.00			
			TOTAL ANCILLARY	17,713.00	13,831.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,713.00	13,831.00

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: 08/24/2017
Run Time: 03:27:49
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	88,158.35	ADJUSTMENTS	0.00
COVERED CHARGES	83,460.45	CONTRACTUAL ALLOW	78,560.45
NON-COVERD CHARGES	4,697.90	TOTAL MEDICAID LIAB	4,900.00
		LESS: COB	0.00
		LESS: COPAYMENT	171.35
		REIMBURSEMENT	4,728.65
		TOTAL NUMBER OF CLAIMS	98

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,956.45	472.00	OTHER LAB	426.00	0.00
MED/SURG SUPPLY	4,673.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,962.00	248.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,980.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,901.00	455.00
EKG/ECG	672.00	112.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	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	162.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	30,663.00	799.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,315.00	1,415.90
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	550.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	750.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	484.00			
			TOTAL ANCILLARY	83,460.45	4,697.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	83,460.45	4,697.90

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

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

Run Date: 08/24/2017
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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JEFF DAVIS HOSPITAL
163 S TALLAHASSEE ST
HAZLEHURST,GA 31539-6465

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,744.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,719.00	CONTRACTUAL ALLOW	1,223.85
NON-COVERD CHARGES	25.00	TOTAL MEDICAID LIAB	1,495.15
		LESS: COB	1,492.15
		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: 08/24/2017
 Run Time: 03:27:49
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JEFF DAVIS HOSPITAL
 163 S TALLAHASSEE ST
 HAZLEHURST,GA 31539-6465

PROVIDER NUMBER
 000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	164.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	187.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	300.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	852.00	25.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	785.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	431.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,719.00	25.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,719.00	25.00

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

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

Run Date: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	31,036.00	ADJUSTMENTS	0.00
COVERED CHARGES	30,882.00	CONTRACTUAL ALLOW	25,925.59
NON-COVERD CHARGES	154.00	TOTAL MEDICAID LIAB	4,956.41
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,956.41
		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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	439.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	124.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,613.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	834.00	0.00
EKG/ECG	118.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	75.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	770.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	26,897.00	154.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	30,882.00	154.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	30,882.00	154.00

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: 08/24/2017
Run Time: 03:27:50
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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	10/01/15	THROUGH	09/30/16
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: 08/24/2017
 Run Time: 03:27:57
 Page: 1

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	99,062.45	ADJUSTMENTS	0.00
COVERED CHARGES	94,789.45	CONTRACTUAL ALLOW	-12,016.26
NON-COVERD CHARGES	4,273.00	TOTAL MEDICAID LIAB	106,805.71
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	106,805.71

TOTAL NUMBER OF ADMISSIONS 13

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	34		0	13,600.00		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	34		0	13,600.00		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	13,600.00		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

JEFFERSON HOSPITAL
 1067 PEACHTREE ST
 LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
 000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,152.00	0.00	OTHER LAB	596.00	0.00
MED/SURG SUPPLY	4,152.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,606.00	0.00	EDUCATION & TRAINING	62.95	0.00
RADIOLOGY-DIAGNOSTIC	2,835.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,450.00	1,930.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,767.00	0.00	MRI SERVICES	1,179.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,771.50	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	11,054.00	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	5,972.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
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	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	356.00	0.00			
			TOTAL ANCILLARY	81,189.45	4,273.00
			TOTAL ACCOMODATIONS	13,600.00	0.00
			TOTAL CHARGES	94,789.45	4,273.00

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 01/01/16 THROUGH 12/31/16
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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	696,095.90	ADJUSTMENTS	3,591.64
COVERED CHARGES	609,668.75	CONTRACTUAL ALLOW	402,998.98
NON-COVERD CHARGES	86,427.15	TOTAL MEDICAID LIAB	206,669.77
		LESS: COB	1,112.07
		LESS: COPAYMENT	558.00
		REIMBURSEMENT	204,999.70
		ALL OTHER	166,345.89
		FEE SCHEDULE-LAB	36,787.17
		INJECTABLE DRUGS	1,866.64
		TOTAL NUMBER OF CLAIMS	1,128

JEFFERSON HOSPITAL
 1067 PEACHTREE ST
 LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
 000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,785.00	2,685.00	OTHER LAB	11,290.00	0.00
MED/SURG SUPPLY	7,752.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	125.90
RADIOLOGY-DIAGNOSTIC	43,155.00	1,794.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	53,243.00	26,709.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,727.00	3,219.00	FEE SCHEDULE LAB	194,935.00	11,243.00
EKG/ECG	10,620.00	3,062.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,692.00	3,199.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,151.50	9,344.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,051.25	5,537.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,870.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	173,180.00	8,415.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,279.00	1,879.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,226.00	2,031.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	23,441.00	2,592.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	32,635.00	1,311.00			
BLOOD	2,412.00	0.00			
BLOOD STORAGE & PRO.	2,412.00	2,343.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,300.00	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	1,512.00	0.00			
			TOTAL ANCILLARY	609,668.75	86,427.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	609,668.75	86,427.15

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

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,634.00	ADJUSTMENTS	0.00
COVERED CHARGES	5,083.00	CONTRACTUAL ALLOW	1,634.98
NON-COVERD CHARGES	1,551.00	TOTAL MEDICAID LIAB	3,448.02
		LESS: COB	3,448.02
		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

JEFFERSON HOSPITAL
 1067 PEACHTREE ST
 LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
 000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 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	22.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	138.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,388.00	1,388.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	858.00	82.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,424.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	118.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	539.00	81.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	596.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	5,083.00	1,551.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,083.00	1,551.00

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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JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	67,377.50	ADJUSTMENTS	0.00
COVERED CHARGES	59,767.00	CONTRACTUAL ALLOW	52,998.26
NON-COVERD CHARGES	7,610.50	TOTAL MEDICAID LIAB	6,768.74
		LESS: COB	15.00
		LESS: COPAYMENT	204.67
		REIMBURSEMENT	6,549.07
		TOTAL NUMBER OF CLAIMS	121

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	804.00	114.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	214.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,786.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,142.00	5,590.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,023.00	1,153.00
EKG/ECG	733.50	161.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	56.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	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	37,777.00	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	1,238.00	97.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	59,767.00	7,610.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	59,767.00	7,610.50

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

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	971.00	ADJUSTMENTS	0.00
COVERED CHARGES	956.00	CONTRACTUAL ALLOW	688.24
NON-COVERD CHARGES	15.00	TOTAL MEDICAID LIAB	267.76
		LESS: COB	267.76
		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

JEFFERSON HOSPITAL
 1067 PEACHTREE ST
 LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
 000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 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	138.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	148.00	15.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	632.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	38.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	956.00	15.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	956.00	15.00

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

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/16	THROUGH	12/31/16
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: 08/24/2017
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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	01/01/16	THROUGH	12/31/16
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: 08/24/2017
 Run Time: 03:28:19
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	216,644.06	ADJUSTMENTS	12,435.60
COVERED CHARGES	133,965.26	CONTRACTUAL ALLOW	50,287.72
NON-COVERD CHARGES	82,678.80	TOTAL MEDICAID LIAB	83,677.54
		LESS: COB	2,302.32
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	81,375.22

TOTAL NUMBER OF ADMISSIONS 16

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	33		4	29,892.00		81,108.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	33		4	29,892.00		81,108.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	33		4	29,892.00		81,108.00

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,449.80	0.00	OTHER LAB	1,639.70	0.00
MED/SURG SUPPLY	9,366.85	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,313.68	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,719.90	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,837.75	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	428.58	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,552.05	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,882.60	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	5,250.34	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,051.03	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,010.80	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,184.00	1,570.80			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,783.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,603.18	0.00			
			TOTAL ANCILLARY	104,073.26	1,570.80
			TOTAL ACCOMODATIONS	29,892.00	81,108.00
			TOTAL CHARGES	133,965.26	82,678.80

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	01/01/16	THROUGH	12/31/16
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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,732,024.80	ADJUSTMENTS	81,850.03
COVERED CHARGES	1,645,259.64	CONTRACTUAL ALLOW	1,178,083.00
NON-COVERD CHARGES	86,765.16	TOTAL MEDICAID LIAB	467,176.64
		LESS: COB	1,220.88
		LESS: COPAYMENT	711.00
		REIMBURSEMENT	465,244.76
		ALL OTHER	371,339.60
		FEE SCHEDULE-LAB	93,905.16
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	1,737

SUMMARY TYPE III
 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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	65,035.20	0.00	OTHER LAB	12,791.20	0.00
MED/SURG SUPPLY	10,737.88	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,183.80	EDUCATION & TRAINING	0.00	238.60
RADIOLOGY-DIAGNOSTIC	43,801.71	440.60	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	95,113.85	15,752.90	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	11,364.62	26,922.97	FEE SCHEDULE LAB	508,985.09	14,699.72
EKG/ECG	15,348.05	1,379.60	MRI SERVICES	0.00	0.00
IV THERAPY	37,094.95	3,469.02	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	603,496.30	7,557.24	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	18,338.95	4,165.17	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	153,990.84	7,014.15	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,282.35	0.00			
BLOOD	577.20	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	11,098.90	2,621.10			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	49,746.55	927.59			
			TOTAL ANCILLARY	1,645,259.64	86,765.16
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,645,259.64	86,765.16

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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,208.72	ADJUSTMENTS	0.00
COVERED CHARGES	6,442.12	CONTRACTUAL ALLOW	3,626.58
NON-COVERD CHARGES	766.60	TOTAL MEDICAID LIAB	2,815.54
		LESS: COB	2,815.54
		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

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

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

Run Date: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	278.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,966.05	766.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,489.52	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	696.30	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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,442.12	766.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,442.12	766.60

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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	115,236.96	ADJUSTMENTS	379.00
COVERED CHARGES	106,143.51	CONTRACTUAL ALLOW	98,893.51
NON-COVERD CHARGES	9,093.45	TOTAL MEDICAID LIAB	7,250.00
		LESS: COB	0.00
		LESS: COPAYMENT	336.00
		REIMBURSEMENT	6,914.00
		TOTAL NUMBER OF CLAIMS	145

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,868.05	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	89.92	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,751.40	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,479.35	6,230.40	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,271.50	2,421.24
EKG/ECG	2,069.40	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,142.13	441.81	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,075.02	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	46,409.14	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	596.35	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	5,391.25	0.00			
			TOTAL ANCILLARY	106,143.51	9,093.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	106,143.51	9,093.45

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: 08/24/2017
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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	01/01/16	THROUGH	12/31/16
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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	30,000.00	ADJUSTMENTS	0.00
COVERED CHARGES	30,000.00	CONTRACTUAL ALLOW	20,274.22
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	9,725.78
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	9,719.78
		TOTAL NUMBER OF CLAIMS	2

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 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	30,000.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	30,000.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	30,000.00	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: 08/24/2017
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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	01/01/16	THROUGH	12/31/16
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: 08/24/2017
 Run Time: 03:28:41
 Page: 1

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,644,388.99	ADJUSTMENTS	722,442.75
COVERED CHARGES	15,571,004.99	CONTRACTUAL ALLOW	11,212,435.88
NON-COVERD CHARGES	1,073,384.00	TOTAL MEDICAID LIAB	4,358,569.11
		LESS: COB	38,150.61
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,320,418.50

TOTAL NUMBER OF ADMISSIONS 468

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,663		1	2,166,281.00		726,292.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,663		1	2,166,281.00		726,292.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	917		0	2,521,353.00		82,137.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	917		0	2,521,353.00		82,137.00
TOTAL ACCOMODATIONS	2,580		1	4,687,634.00		808,429.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	970,391.20	33,443.00	OTHER LAB	120,409.00	1,835.00
MED/SURG SUPPLY	102,374.00	9,044.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,251,849.00	21,496.00	EDUCATION & TRAINING	4,060.00	0.00
RADIOLOGY-DIAGNOSTIC	479,461.00	5,696.00	OTHER THERAPEUTIC SVC	0.00	6,394.00
CT SCAN	1,036,227.00	52,466.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	74,813.11	2,688.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	210,940.00	0.00	MRI SERVICES	172,091.00	0.00
IV THERAPY	277,006.00	641.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,360,160.00	7,338.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	650,638.00	2,270.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	287,190.00	729.00	AMBULANCE	0.00	0.00
GI SERVICES	86,573.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	932,957.00	177.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	209,737.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	105,351.00	0.00	INJECTABLE DRUGS	841,232.41	21,537.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	23,175.03	1,783.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	22,229.24	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	546,840.00	22,785.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	544.00	1,400.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	235,522.00	5,456.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	54,917.00
OTHER IMAGING SERVICE	98,490.00	11,664.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	80,323.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	163,508.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	467,410.00	1,196.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	27,326.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	44,544.00	0.00			
			TOTAL ANCILLARY	10,883,370.99	264,955.00
			TOTAL ACCOMODATIONS	4,687,634.00	808,429.00
			TOTAL CHARGES	15,571,004.99	1,073,384.00

GWINNETT MEDICAL CENTER-DULUTH
 3620 HOWELL FERRY RD
 DULUTH,GA 30096-3178

PROVIDER NUMBER
 000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2315309000055	08/08/15 - 08/11/15	12/14/15	0.00	4,348.00	0.00	0.00	0.00
615	5215362000764	07/05/15 - 07/09/15	02/22/16	0.00	2,363.00	0.00	0.00	0.00
615	5215362017491	09/04/15 - 09/06/15	02/22/16	0.00	4,348.00	0.00	0.00	0.00
615	5215362018994	08/28/15 - 09/14/15	02/22/16	0.00	4,348.00	0.00	0.00	0.00
615	5215363003969	09/14/15 - 09/15/15	02/22/16	0.00	4,348.00	0.00	0.00	0.00
615	2016077002424	10/08/15 - 10/09/15	03/21/16	0.00	4,348.00	0.00	0.00	0.00
615	2216110007626	03/15/16 - 04/01/16	04/25/16	0.00	6,711.00	0.00	0.00	0.00
615	2016153005740	12/15/15 - 12/18/15	06/06/16	0.00	4,348.00	0.00	0.00	0.00
615	2016169067376	01/01/16 - 01/03/16	06/27/16	0.00	2,363.00	0.00	0.00	0.00
615	2316201000122	03/16/16 - 03/18/16	08/08/16	0.00	4,348.00	0.00	0.00	0.00
615	2016259088033	08/18/15 - 08/31/15	09/19/16	0.00	4,348.00	0.00	0.00	0.00
615	2016328093413	04/21/16 - 04/28/16	11/28/16	0.00	4,348.00	0.00	0.00	0.00
615	2017073085697	03/29/16 - 04/03/16	03/20/17	0.00	4,348.00	0.00	0.00	0.00
TOTAL				0.00	54,917.00	0.00	0.00	0.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	714,022.55	ADJUSTMENTS	0.00
COVERED CHARGES	705,062.55	CONTRACTUAL ALLOW	225,198.31
NON-COVERD CHARGES	8,960.00	TOTAL MEDICAID LIAB	479,864.24
		LESS: COB	479,864.24
		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	21		0	30,135.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	21		0	30,135.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	61		0	226,943.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	61		0	226,943.00		0.00
TOTAL ACCOMODATIONS	82		0	257,078.00		0.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	120,793.00	0.00	OTHER LAB	3,670.00	0.00
MED/SURG SUPPLY	13,555.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	53,839.00	0.00	EDUCATION & TRAINING	210.00	0.00
RADIOLOGY-DIAGNOSTIC	21,868.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,926.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	476.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	796.00	0.00	MRI SERVICES	7,134.00	0.00
IV THERAPY	1,529.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	49,627.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	69,151.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,762.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,047.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,603.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,265.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	4,447.00	0.00	INJECTABLE DRUGS	22,580.55	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	25,823.00	8,960.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,027.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,995.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,561.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,300.00	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	0.00	0.00			
			TOTAL ANCILLARY	447,984.55	8,960.00
			TOTAL ACCOMODATIONS	257,078.00	0.00
			TOTAL CHARGES	705,062.55	8,960.00

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: 08/24/2017
Run Time: 03:28:47
Page: 6

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,862,277.00	ADJUSTMENTS	124,199.67
COVERED CHARGES	6,175,696.88	CONTRACTUAL ALLOW	5,107,912.92
NON-COVERD CHARGES	686,580.12	TOTAL MEDICAID LIAB	1,067,783.96
		LESS: COB	205.44
		LESS: COPAYMENT	1,470.00
		REIMBURSEMENT	1,066,108.52
		ALL OTHER	974,181.98
		FEE SCHEDULE-LAB	73,287.71
		INJECTABLE DRUGS	18,638.83

TOTAL NUMBER OF CLAIMS 2,081

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	170,520.60	501.00	OTHER LAB	91,009.00	0.00
MED/SURG SUPPLY	36,861.00	621.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	2,934.00	EDUCATION & TRAINING	0.00	140.00
RADIOLOGY-DIAGNOSTIC	408,046.00	3,077.00	OTHER THERAPEUTIC SVC	0.00	28,495.00
CT SCAN	782,078.00	173,386.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,324.00	1,090.00	FEE SCHEDULE LAB	689,794.00	38,659.00
EKG/ECG	107,338.00	796.00	MRI SERVICES	100,895.00	32,553.00
IV THERAPY	383,977.00	10,004.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	664,026.08	76,656.92	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	18,287.00	6,077.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	173,510.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	197,402.00	22,620.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,566,102.00	2,272.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	146,861.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	220,525.20	45,048.20
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,164.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	179.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	79,064.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	986.00	204.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,919.00	59,220.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,805.00
OTHER IMAGING SERVICE	158,953.00	44,252.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,320.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	73,423.00	36,186.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	56,786.00	16,567.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	103,590.00	2,304.00			
			TOTAL ANCILLARY	6,175,696.88	685,711.12
			TOTAL ACCOMODATIONS	0.00	869.00
			TOTAL CHARGES	6,175,696.88	686,580.12

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: 08/24/2017
Run Time: 03:28:47
Page: 8

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015244086585	07/21/15 - 07/21/15	09/07/15	0.00	2,805.00	0.00	0.00	0.00
TOTAL				0.00	2,805.00	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: 08/24/2017
Run Time: 03:28:57
Page: 9

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	100,161.00	ADJUSTMENTS	0.00
COVERED CHARGES	85,931.00	CONTRACTUAL ALLOW	48,077.90
NON-COVERD CHARGES	14,230.00	TOTAL MEDICAID LIAB	37,853.10
		LESS: COB	37,844.10
		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

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,859.00	0.00	OTHER LAB	1,835.00	0.00
MED/SURG SUPPLY	439.00	57.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,319.00	527.00	OTHER THERAPEUTIC SVC	0.00	278.00
CT SCAN	11,819.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,359.00	54.00
EKG/ECG	1,194.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,330.00	137.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,915.00	9,493.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	161.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,833.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,460.00	94.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,026.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,554.00	509.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	812.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	948.00	2,269.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,880.00	0.00			
			TOTAL ANCILLARY	85,931.00	14,230.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	85,931.00	14,230.00

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: 08/24/2017
Run Time: 03:28:58
Page: 11

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	537,800.50	ADJUSTMENTS	273.70
COVERED CHARGES	497,240.50	CONTRACTUAL ALLOW	478,276.84
NON-COVERD CHARGES	40,560.00	TOTAL MEDICAID LIAB	18,963.66
		LESS: COB	0.00
		LESS: COPAYMENT	526.58
		REIMBURSEMENT	18,437.08
		TOTAL NUMBER OF CLAIMS	339

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,047.00	0.00	OTHER LAB	3,110.00	0.00
MED/SURG SUPPLY	324.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	39,541.00	0.00	OTHER THERAPEUTIC SVC	0.00	5,977.00
CT SCAN	36,140.00	20,084.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	70,014.00	4,233.00
EKG/ECG	7,960.00	0.00	MRI SERVICES	0.00	3,152.00
IV THERAPY	31,004.00	137.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	966.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	273,853.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	15,849.50	492.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,432.00	6,485.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	497,240.50	40,560.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	497,240.50	40,560.00

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: 08/24/2017
 Run Time: 03:29:00
 Page: 13

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,588.00	ADJUSTMENTS	0.00
COVERED CHARGES	6,337.00	CONTRACTUAL ALLOW	-3,203.22
NON-COVERD CHARGES	6,251.00	TOTAL MEDICAID LIAB	9,540.22
		LESS: COB	9,531.22
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	243.00	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	5,440.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	746.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,188.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,225.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	788.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,147.00	811.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,337.00	6,251.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,337.00	6,251.00

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: 08/24/2017
Run Time: 03:29:00
Page: 15

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	39,967.00	ADJUSTMENTS	0.00
COVERED CHARGES	32,683.33	CONTRACTUAL ALLOW	27,156.86
NON-COVERD CHARGES	7,283.67	TOTAL MEDICAID LIAB	5,526.47
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	5,517.47
		TOTAL NUMBER OF CLAIMS	1

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,792.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	296.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,382.00	27.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,327.33	7,163.67	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,783.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,596.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,475.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	401.00	93.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,631.00	0.00			
			TOTAL ANCILLARY	32,683.33	7,283.67
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	32,683.33	7,283.67

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: 08/24/2017
Run Time: 03:29:01
Page: 17

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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
 Run Time: 03:26:44
 Page: 1

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 10/01/15 THROUGH 05/12/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	252,867.99	ADJUSTMENTS	23,325.94
COVERED CHARGES	252,867.99	CONTRACTUAL ALLOW	186,461.00
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	66,406.99
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	66,406.99

TOTAL NUMBER OF ADMISSIONS 8

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	27		0	28,026.00		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	27		0	28,026.00		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	27		0	28,026.00		0.00

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 10/01/15 THROUGH 05/12/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57,814.96	0.00	OTHER LAB	761.00	0.00
MED/SURG SUPPLY	4,009.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	60,449.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,292.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	24,071.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	581.03	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,775.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,032.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,401.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	27,936.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,408.00	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	605.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	985.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,738.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,630.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,354.00	0.00			
			TOTAL ANCILLARY	224,841.99	0.00
			TOTAL ACCOMODATIONS	28,026.00	0.00
			TOTAL CHARGES	252,867.99	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: 08/24/2017
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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	10/01/15	THROUGH	05/12/16
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: 08/24/2017
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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 10/01/15 THROUGH 05/12/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,566,192.15	ADJUSTMENTS	124,245.65
COVERED CHARGES	2,387,135.04	CONTRACTUAL ALLOW	2,003,057.40
NON-COVERD CHARGES	179,057.11	TOTAL MEDICAID LIAB	384,077.64
		LESS: COB	91.00
		LESS: COPAYMENT	345.00
		REIMBURSEMENT	383,641.64
		ALL OTHER	344,521.05
		FEE SCHEDULE-LAB	25,284.83
		INJECTABLE DRUGS	13,835.76

TOTAL NUMBER OF CLAIMS 1,032

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: 08/24/2017
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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 10/01/15 THROUGH 05/12/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	68,988.65	347.00	OTHER LAB	4,830.00	0.00
MED/SURG SUPPLY	8,663.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	122,401.00	0.00	OTHER THERAPEUTIC SVC	0.00	283.00
CT SCAN	251,907.00	102,345.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,344.00	5,620.00	FEE SCHEDULE LAB	399,173.52	30,649.20
EKG/ECG	45,440.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	266,398.00	3,188.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,108.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	39,473.00	6,902.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,025.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	13,210.00	2,262.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	934,492.00	1,346.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,481.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	119,861.87	11,850.91
RADIOLOGY THERAPEUTIC	27,047.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	317.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,290.00	3,680.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	1,664.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,508.00	1,522.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,425.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	17,804.00	4,451.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,950.00	2,630.00			
AMBULATORY SURGERY	12,780.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,535.00	0.00			
			TOTAL ANCILLARY	2,387,135.04	179,057.11
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,387,135.04	179,057.11

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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SUMMARY TYPE IV

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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 10/01/15 THROUGH 05/12/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	45,136.70	ADJUSTMENTS	0.00
COVERED CHARGES	25,679.93	CONTRACTUAL ALLOW	3,402.60
NON-COVERD CHARGES	19,456.77	TOTAL MEDICAID LIAB	22,277.33
		LESS: COB	22,265.33
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 10

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 10/01/15 THROUGH 05/12/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,209.35	18,402.07	OTHER LAB	283.00	0.00
MED/SURG SUPPLY	222.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	997.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,981.72	270.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,631.00	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	394.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,987.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,513.86	94.70
RADIOLOGY THERAPEUTIC	3,461.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	460.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	25,679.93	19,456.77
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,679.93	19,456.77

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

HUTCHESON MEDICAL CENTER	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
100 GROSS CRESCENT CIR	000001075A	SERVICE DATES	10/01/15	THROUGH	05/12/16
FORT OGLETHORPE, GA 30742-3643		ADMISSION DATES	00/00/00	THROUGH	00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
355	2216025006077	11/03/15 - 11/03/15	02/01/16	0.00	460.00	0.00	11,239.05	0.00
TOTAL				0.00	460.00	0.00	11,239.05	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

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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 10/01/15 THROUGH 05/12/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	164,579.72	ADJUSTMENTS	419.69
COVERED CHARGES	160,814.37	CONTRACTUAL ALLOW	151,975.85
NON-COVERD CHARGES	3,765.35	TOTAL MEDICAID LIAB	8,838.52
		LESS: COB	0.00
		LESS: COPAYMENT	336.03
		REIMBURSEMENT	8,502.49
		TOTAL NUMBER OF CLAIMS	158

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 10/01/15 THROUGH 05/12/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,491.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	242.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,820.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,263.00	2,682.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	15,696.00	760.00
EKG/ECG	1,065.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	17,972.00	259.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,249.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	98,742.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,273.62	64.35
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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	160,814.37	3,765.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	160,814.37	3,765.35

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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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	10/01/15	THROUGH	05/12/16
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

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 10/01/15 THROUGH 05/12/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	311,741.46	ADJUSTMENTS	5,925.61
COVERED CHARGES	307,970.01	CONTRACTUAL ALLOW	260,516.55
NON-COVERD CHARGES	3,771.45	TOTAL MEDICAID LIAB	47,453.46
		LESS: COB	0.00
		LESS: COPAYMENT	57.00
		REIMBURSEMENT	47,396.46

TOTAL NUMBER OF CLAIMS 8

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 10/01/15 THROUGH 05/12/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,315.20	0.00	OTHER LAB	1,981.00	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	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,515.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,264.20	378.00
EKG/ECG	355.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,858.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	254.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	67.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,926.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	255,751.61	3,393.45
RADIOLOGY THERAPEUTIC	27,824.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	307,970.01	3,771.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	307,970.01	3,771.45

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: 08/24/2017
Run Time: 03:26:54
Page: 14

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 10/01/15 THROUGH 05/12/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	76,877.07	ADJUSTMENTS	0.00
COVERED CHARGES	73,603.67	CONTRACTUAL ALLOW	35,827.21
NON-COVERD CHARGES	3,273.40	TOTAL MEDICAID LIAB	37,776.46
		LESS: COB	37,770.46
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

SUMMARY TYPE VIII

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 10/01/15 THROUGH 05/12/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	690.10	1,734.80	OTHER LAB	0.00	566.00
MED/SURG SUPPLY	196.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	611.72	54.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	547.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	63,444.85	918.60
RADIOLOGY THERAPEUTIC	8,114.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	73,603.67	3,273.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	73,603.67	3,273.40

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

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

Run Date: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,777,213.16	ADJUSTMENTS	1,443,286.10
COVERED CHARGES	13,623,380.16	CONTRACTUAL ALLOW	9,363,320.52
NON-COVERD CHARGES	153,833.00	TOTAL MEDICAID LIAB	4,260,059.64
		LESS: COB	23,934.30
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,236,125.34

TOTAL NUMBER OF ADMISSIONS 661

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,122		2	921,690.00		7,780.00
ROUTINE NURSERY	313		0	246,706.00		388.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,435		2	1,168,396.00		8,168.00
SPECIAL CARE SERVICES						
CCU	310		0	468,300.00		0.00
ICU	202		0	404,202.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	512		0	872,502.00		0.00
TOTAL ACCOMODATIONS	1,947		2	2,040,898.00		8,168.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	622,100.55	0.00	OTHER LAB	72,266.50	0.00
MED/SURG SUPPLY	568,340.98	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,095,438.45	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	208,490.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	780,231.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	57,628.75	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	276,378.50	0.00	MRI SERVICES	91,883.50	0.00
IV THERAPY	15,624.25	0.00	PROFESSIONAL FEES	0.00	484.00
OPERATING ROOM	2,165,073.50	3,506.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	464,095.32	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	426,848.75	2,540.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	299,230.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	812,418.65	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	158,091.88	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	64,538.50	0.00	INJECTABLE DRUGS	1,128,803.58	0.00
RADIOLOGY THERAPEUTIC	20,231.19	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,349.25	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,029.25	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	45,234.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,031.00	23,990.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	244,143.06	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	7,422.00
OTHER IMAGING SERVICE	77,678.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	141,793.75	97,970.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	63,061.00	9,751.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	643,940.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	23,507.75	0.00			
			TOTAL ANCILLARY	11,582,482.16	145,665.00
			TOTAL ACCOMODATIONS	2,040,898.00	8,168.00
			TOTAL CHARGES	13,623,380.16	153,833.00

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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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5215362019276	08/26/15 - 08/29/15	02/22/16	0.00	2,474.00	0.00	0.00	0.00
615	9716105981002	07/22/15 - 07/29/15	04/18/16	0.00	2,474.00	0.00	0.00	0.00
615	2016224080279	06/09/16 - 06/11/16	08/15/16	0.00	2,474.00	0.00	0.00	0.00
TOTAL				0.00	7,422.00	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

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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,579,706.65	ADJUSTMENTS	243,895.98
COVERED CHARGES	15,650,279.98	CONTRACTUAL ALLOW	13,122,471.77
NON-COVERD CHARGES	1,929,426.67	TOTAL MEDICAID LIAB	2,527,808.21
		LESS: COB	1,856.42
		LESS: COPAYMENT	10,490.14
		REIMBURSEMENT	2,515,461.65
		ALL OTHER	2,154,457.11
		FEE SCHEDULE-LAB	167,512.01
		INJECTABLE DRUGS	193,492.53

TOTAL NUMBER OF CLAIMS 5,788

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	107,436.81	3,068.56	OTHER LAB	93,060.50	1,930.50
MED/SURG SUPPLY	406,724.04	19,140.52	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	235.50	EDUCATION & TRAINING	183.75	0.00
RADIOLOGY-DIAGNOSTIC	676,676.00	21,684.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,807,756.25	114,744.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	48,700.00	10,582.30	FEE SCHEDULE LAB	2,135,018.02	66,671.00
EKG/ECG	196,153.00	945.75	MRI SERVICES	668,694.50	30,895.75
IV THERAPY	126,787.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,929,605.50	445,098.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	412,360.75	143,761.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	307,053.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,510,000.50	8,151.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	155,825.58	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	260,044.76	110,003.87
RADIOLOGY THERAPEUTIC	664,149.90	146,137.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	13,502.25	4,019.25	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,604.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,022,666.27	45,107.45	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	59,833.85	94,445.97
LITHOTRIpsy	105,702.50	0.00	NO CC/INVALID REV CODE	10.00	715.00
OTHER IMAGING SERVICE	442,249.00	57,512.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	67,570.75	2,055.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	481,155.50	153,985.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	574,352.00	427,428.00			
AMBULATORY SURGERY	76,887.50	16,953.50			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	174,325.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	125,794.25	2,551.25			
			TOTAL ANCILLARY	15,650,279.98	1,929,426.67
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,650,279.98	1,929,426.67

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
7120	9816047000037	07/29/15 - 07/29/15	02/22/16	10.00	0.00	0.00	0.00	0.00
445	2217027014133	06/06/16 - 06/06/16	01/30/17	0.00	715.00	0.00	0.00	0.00
TOTAL				10.00	715.00	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: 08/24/2017
Run Time: 03:39:28
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	119,418.41	ADJUSTMENTS	0.00
COVERED CHARGES	25,808.36	CONTRACTUAL ALLOW	15,053.96
NON-COVERD CHARGES	93,610.05	TOTAL MEDICAID LIAB	10,754.40
		LESS: COB	10,745.40
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 15

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	74.80	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,173.35	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	990.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	4,825.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,249.25	36.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	175.00
OPERATING ROOM	10,834.25	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	83,820.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	920.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,961.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	502.20	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	276.26	85.80
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	5,088.75	1,403.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	728.00	2,275.25			
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	25,808.36	93,610.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,808.36	93,610.05

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: 08/24/2017
Run Time: 03:39:29
Page: 10

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	765,884.72	ADJUSTMENTS	158.82
COVERED CHARGES	746,525.03	CONTRACTUAL ALLOW	713,576.37
NON-COVERD CHARGES	19,359.69	TOTAL MEDICAID LIAB	32,948.66
		LESS: COB	16.75
		LESS: COPAYMENT	1,177.04
		REIMBURSEMENT	31,754.87
		TOTAL NUMBER OF CLAIMS	589

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,068.73	0.00	OTHER LAB	1,930.50	0.00
MED/SURG SUPPLY	3,964.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	49,120.50	406.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	77,517.25	7,500.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	127,159.25	3,961.25
EKG/ECG	11,979.50	0.00	MRI SERVICES	0.00	4,291.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,118.00	131.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	449,255.50	242.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,689.35	104.44
RADIOLOGY THERAPEUTIC	1,400.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	67.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,321.75	2,656.75			
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	746,525.03	19,359.69
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	746,525.03	19,359.69

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: 08/24/2017
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Page: 12

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,918.55	ADJUSTMENTS	0.00
COVERED CHARGES	7,918.55	CONTRACTUAL ALLOW	7,749.19
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	169.36
		LESS: COB	160.36
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	47.28	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,379.75	0.00
EKG/ECG	315.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,442.75	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	13.27	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL 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	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,918.55	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,918.55	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

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	996,316.93	ADJUSTMENTS	64,238.16
COVERED CHARGES	920,096.95	CONTRACTUAL ALLOW	756,204.09
NON-COVERD CHARGES	76,219.98	TOTAL MEDICAID LIAB	163,892.86
		LESS: COB	0.00
		LESS: COPAYMENT	301.60
		REIMBURSEMENT	163,591.26
		TOTAL NUMBER OF CLAIMS	28

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,374.54	280.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	40,920.38	1,902.83	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,805.50	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	411.75	FEE SCHEDULE LAB	30,287.00	72.00
EKG/ECG	1,261.00	0.00	MRI SERVICES	0.00	4,152.50
IV THERAPY	32,152.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	162,500.25	883.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	278,396.00	17,780.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	20,677.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,235.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,801.20	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	139,993.29	4,140.02
RADIOLOGY THERAPEUTIC	47,639.25	7,350.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	292.25	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	58,054.50	9,540.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,908.29	29,415.38
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	61,029.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,062.00	0.00			
			TOTAL ANCILLARY	920,096.95	76,219.98
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	920,096.95	76,219.98

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: 08/24/2017
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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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
 Run Time: 03:57:43
 Page: 1

NORTHSIDE HOSPITAL, INC
 450 NORTHSIDE CHEROKEE BLVD
 CANTON,GA 30115-8015

PROVIDER NUMBER 000001108A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,257,419.79	ADJUSTMENTS	608,870.64
COVERED CHARGES	21,330,330.79	CONTRACTUAL ALLOW	17,063,409.50
NON-COVERD CHARGES	927,089.00	TOTAL MEDICAID LIAB	4,266,921.29
		LESS: COB	18,941.43
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,247,979.86

TOTAL NUMBER OF ADMISSIONS 726

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,833		6	1,969,753.00		489,251.00
ROUTINE NURSERY	567		0	664,658.00		40,741.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,400		6	2,634,411.00		529,992.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	259		0	1,024,755.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	259		0	1,024,755.00		0.00
TOTAL ACCOMODATIONS	2,659		6	3,659,166.00		529,992.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL, INC
 450 NORTHSIDE CHEROKEE BLVD
 CANTON,GA 30115-8015

PROVIDER NUMBER
 000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,549,535.00	31,459.00	OTHER LAB	48,183.00	0.00
MED/SURG SUPPLY	984,540.50	14,996.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,935,560.79	42,223.00	EDUCATION & TRAINING	468.00	0.00
RADIOLOGY-DIAGNOSTIC	278,480.00	389.00	OTHER THERAPEUTIC SVC	0.00	8,541.00
CT SCAN	799,321.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	146,230.00	5,480.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	103,261.00	666.00	MRI SERVICES	166,607.00	0.00
IV THERAPY	99,051.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,737,882.00	29,100.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	892,728.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,209,387.00	12,386.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	253,179.00	4,498.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	532,470.00	180.00	SPECIAL SERVICES	0.00	32,207.00
RECOVERY ROOM	182,275.00	2,832.00	DRUG-SPECIFIC/HOME IV	0.00	19,099.50
LABORATORY PATHOLOGIC	148,340.00	429.00	INJECTABLE DRUGS	3,841,766.50	81,822.50
RADIOLOGY THERAPEUTIC	77,388.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	58,028.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	49,570.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	123,649.00	6,312.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	38.00	718.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,197.00	399.00	IMPL DEV CHARGE PATIENTS	335,167.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	145,347.00	33,742.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	181,985.00	42,405.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	150,831.00	25,029.00			
AUDIOLOGY	75,555.00	0.00			
CARDIOLOGY	530,994.00	2,054.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	9,316.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	22,835.00	130.00			
			TOTAL ANCILLARY	17,671,164.79	397,097.00
			TOTAL ACCOMODATIONS	3,659,166.00	529,992.00
			TOTAL CHARGES	21,330,330.79	927,089.00

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

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

Run Date: 08/24/2017
 Run Time: 03:57:48
 Page: 3

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL, INC
 450 NORTHSIDE CHEROKEE BLVD
 CANTON,GA 30115-8015

PROVIDER NUMBER 000001108A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	112,009.50	ADJUSTMENTS	0.00
COVERED CHARGES	109,978.50	CONTRACTUAL ALLOW	62,460.59
NON-COVERD CHARGES	2,031.00	TOTAL MEDICAID LIAB	47,517.91
		LESS: COB	47,517.91
		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	20,583.00		1,381.00
ROUTINE NURSERY	5		0	3,245.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	24		0	23,828.00		1,381.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	24		0	23,828.00		1,381.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL, INC
 450 NORTHSIDE CHEROKEE BLVD
 CANTON,GA 30115-8015

PROVIDER NUMBER
 000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,424.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,627.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,856.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,277.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,495.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	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	10,488.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	14,469.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,764.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,074.00	0.00	SPECIAL SERVICES	0.00	650.00
RECOVERY ROOM	1,122.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,382.00	0.00	INJECTABLE DRUGS	7,720.50	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	1,201.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	585.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	86,150.50	650.00
			TOTAL ACCOMODATIONS	23,828.00	1,381.00
			TOTAL CHARGES	109,978.50	2,031.00

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: 08/24/2017
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NORTHSIDE HOSPITAL, INC
450 NORTHSIDE CHEROKEE BLVD
CANTON,GA 30115-8015

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,884,209.07	ADJUSTMENTS	632,914.91
COVERED CHARGES	14,353,667.27	CONTRACTUAL ALLOW	12,335,930.06
NON-COVERD CHARGES	1,530,541.80	TOTAL MEDICAID LIAB	2,017,737.21
		LESS: COB	7,156.83
		LESS: COPAYMENT	3,426.00
		REIMBURSEMENT	2,007,154.38
		ALL OTHER	1,773,149.08
		FEE SCHEDULE-LAB	122,183.63
		INJECTABLE DRUGS	111,821.67

TOTAL NUMBER OF CLAIMS 3,022

SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL, INC
 450 NORTHSIDE CHEROKEE BLVD
 CANTON,GA 30115-8015

PROVIDER NUMBER
 000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	348,096.50	3,313.00	OTHER LAB	104,824.00	0.00
MED/SURG SUPPLY	515,249.00	32,990.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	5,137.00	EDUCATION & TRAINING	272.00	0.00
RADIOLOGY-DIAGNOSTIC	479,109.00	2,286.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,897,276.00	312,779.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	32,548.00	20,599.00	FEE SCHEDULE LAB	2,140,543.63	99,211.80
EKG/ECG	202,853.00	5,029.00	MRI SERVICES	431,233.00	64,804.00
IV THERAPY	384,353.00	17,208.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	774,281.00	89,815.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	45,391.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	108,055.00	14,572.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	196,654.00	1,262.00	AMBULANCE	0.00	0.00
GI SERVICES	3,192.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,252,052.00	59,531.00	SPECIAL SERVICES	0.00	1,872.00
RECOVERY ROOM	224,547.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,349.50
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,197,822.50	322,761.50
RADIOLOGY THERAPEUTIC	860,485.00	131,300.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,827.00	2,396.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,220.00	5,714.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	9,332.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,906.00	1,104.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	5,752.00	1,596.00	IMPL DEV CHARGE PATIENTS	108,378.00	2,381.00
LITHOTRIPSY	64,602.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	455,855.00	152,405.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	60,134.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	118,799.00	88,135.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	167,924.00	73,327.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	6,768.00	734.00			
ORGAN ACQUISITION	0.00	4,337.00			
TREATMENT/OBSERV. RM	149,665.64	3,261.00			
			TOTAL ANCILLARY	14,353,667.27	1,530,541.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,353,667.27	1,530,541.80

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
450 NORTHSIDE CHEROKEE BLVD
CANTON,GA 30115-8015

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	293,897.50	ADJUSTMENTS	0.00
COVERED CHARGES	221,868.00	CONTRACTUAL ALLOW	140,617.29
NON-COVERD CHARGES	72,029.50	TOTAL MEDICAID LIAB	81,250.71
		LESS: COB	81,223.71
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 72

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

NORTHSIDE HOSPITAL, INC
 450 NORTHSIDE CHEROKEE BLVD
 CANTON,GA 30115-8015

PROVIDER NUMBER
 000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,158.50	0.00	OTHER LAB	1,266.00	0.00
MED/SURG SUPPLY	7,116.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,049.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,919.00	19,272.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	39,187.00	773.00
EKG/ECG	2,997.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	540.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,426.00	11,883.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,687.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,304.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	70,082.00	1,066.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,200.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,971.50	13,967.50
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	726.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	198.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,339.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	23,877.00	21,805.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,551.00	2,537.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	221,868.00	72,029.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	221,868.00	72,029.50

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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NORTHSIDE HOSPITAL, INC
450 NORTHSIDE CHEROKEE BLVD
CANTON,GA 30115-8015

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	769,718.50	ADJUSTMENTS	1,600.40
COVERED CHARGES	708,256.00	CONTRACTUAL ALLOW	691,697.76
NON-COVERD CHARGES	61,462.50	TOTAL MEDICAID LIAB	16,558.24
		LESS: COB	0.00
		LESS: COPAYMENT	523.27
		REIMBURSEMENT	16,034.97
		TOTAL NUMBER OF CLAIMS	296

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL, INC
 450 NORTHSIDE CHEROKEE BLVD
 CANTON,GA 30115-8015

PROVIDER NUMBER
 000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,042.50	34.00	OTHER LAB	4,474.00	0.00
MED/SURG SUPPLY	14,828.00	22.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,197.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	35,422.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	99,013.00	32,803.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	142,002.00	7,333.00
EKG/ECG	10,653.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	177.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,768.00	155.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	337,933.00	4,569.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	35,020.50	5,083.50
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	38.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	1,197.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,923.00	9,031.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	708,256.00	61,462.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	708,256.00	61,462.50

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

NORTHSIDE HOSPITAL, INC
450 NORTHSIDE CHEROKEE BLVD
CANTON,GA 30115-8015

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,457.00	ADJUSTMENTS	0.00
COVERED CHARGES	22,213.00	CONTRACTUAL ALLOW	15,953.43
NON-COVERD CHARGES	4,244.00	TOTAL MEDICAID LIAB	6,259.57
		LESS: COB	6,253.57
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL, INC
 450 NORTHSIDE CHEROKEE BLVD
 CANTON,GA 30115-8015

PROVIDER NUMBER
 000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	60.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	221.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	778.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,520.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,511.00	1,560.00
EKG/ECG	1,665.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,978.00	81.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	83.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	22,213.00	4,244.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	22,213.00	4,244.00

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

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

Run Date: 08/24/2017
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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL, INC
450 NORTHSIDE CHEROKEE BLVD
CANTON,GA 30115-8015

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,861,101.59	ADJUSTMENTS	81,573.00
COVERED CHARGES	1,621,356.59	CONTRACTUAL ALLOW	1,458,911.59
NON-COVERD CHARGES	239,745.00	TOTAL MEDICAID LIAB	162,445.00
		LESS: COB	0.00
		LESS: COPAYMENT	135.00
		REIMBURSEMENT	162,310.00
		TOTAL NUMBER OF CLAIMS	30

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

NORTHSIDE HOSPITAL, INC
 450 NORTHSIDE CHEROKEE BLVD
 CANTON,GA 30115-8015

PROVIDER NUMBER
 000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,210.00	0.00	OTHER LAB	2,068.00	0.00
MED/SURG SUPPLY	167,331.00	233.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,768.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	30,265.00	13,439.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,274.00	FEE SCHEDULE LAB	57,714.00	3,412.00
EKG/ECG	5,328.00	666.00	MRI SERVICES	9,282.00	4,786.00
IV THERAPY	50,582.00	4,613.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	242,041.00	47,599.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,618.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	35,962.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,764.00	1,234.00	SPECIAL SERVICES	0.00	234.00
RECOVERY ROOM	28,815.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	523,268.00	125,724.00
RADIOLOGY THERAPEUTIC	113,937.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	206,163.00	16,402.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,816.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,691.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,799.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	24,453.00	19,129.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,481.59	0.00			
			TOTAL ANCILLARY	1,621,356.59	239,745.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,621,356.59	239,745.00

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: 08/24/2017
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Page: 15

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL, INC
450 NORTHSIDE CHEROKEE BLVD
CANTON,GA 30115-8015

PROVIDER NUMBER
000001108A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/15	THROUGH	09/30/16
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: 08/24/2017
 Run Time: 03:31:17
 Page: 1

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	131,580,360.82	ADJUSTMENTS	5,759,740.32
COVERED CHARGES	127,824,955.08	CONTRACTUAL ALLOW	103,950,355.73
NON-COVERD CHARGES	3,755,405.74	TOTAL MEDICAID LIAB	23,874,599.35
		LESS: COB	281,602.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	23,592,997.35

TOTAL NUMBER OF ADMISSIONS 2,657

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	8,932		9	9,831,644.00		1,323,514.00
ROUTINE NURSERY	1,859		0	2,262,105.00		87,680.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	10,791		9	12,093,749.00		1,411,194.00
SPECIAL CARE SERVICES						
CCU	2,896		0	6,601,161.75		286,672.25
ICU	1,999		0	5,962,214.00		165,420.00
NICU	742		0	2,328,890.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	119		0	585,242.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	5,756		0	15,477,507.75		452,092.25
TOTAL ACCOMODATIONS	16,547		9	27,571,256.75		1,863,286.25

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

WELLSTAR KENNESTONE HOSPITAL PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
 677 CHURCH ST NE 000001119A SERVICE DATES 07/01/15 THROUGH 06/30/16
 MARIETTA,GA 30060-1101 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,286,979.04	509,441.66	OTHER LAB	1,087,144.00	15,250.00
MED/SURG SUPPLY	6,173,769.99	99,313.49	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	15,247,942.00	141,713.00	EDUCATION & TRAINING	85,724.00	0.00
RADIOLOGY-DIAGNOSTIC	2,541,688.00	32,161.00	OTHER THERAPEUTIC SVC	0.00	24,284.00
CT SCAN	7,363,393.00	90,394.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	857,176.83	84,640.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	843,494.00	4,123.00	MRI SERVICES	1,945,911.00	15,195.00
IV THERAPY	1,422,569.00	55,228.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,119,660.00	56,840.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,375,644.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,390,600.00	85,791.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,282,970.00	17,112.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,284,677.00	4,975.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,706,970.00	20,382.00	DRUG-SPECIFIC/HOME IV	0.00	5,486.50
LABORATORY PATHOLOGIC	584,911.00	3,007.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	441,940.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	365,095.34	22,394.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	358,166.59	50,439.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	2,510,523.00	143,712.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	107,448.00	18,915.00	TRAUMA RESPONSE	0.00	188,165.00
PSYCHIATRIC SERVICES	5,550.00	0.00	IMPL DEV CHARGE PATIENTS	3,770,104.83	70,707.84
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	153.00
OTHER IMAGING SERVICE	587,806.00	10,465.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,570,926.00	94,707.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	576,343.00	1,786.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,233,702.00	8,729.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	471,852.00	8,592.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	653,018.71	8,018.00			
			TOTAL ANCILLARY	100,253,698.33	1,892,119.49
			TOTAL ACCOMODATIONS	27,571,256.75	1,863,286.25
			TOTAL CHARGES	127,824,955.08	3,755,405.74

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: 08/24/2017
Run Time: 03:31:17
Page: 3

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2217054009582	02/09/16 - 02/14/16	02/27/17	0.00	153.00	0.00	0.00	0.00
TOTAL				0.00	153.00	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: 08/24/2017
 Run Time: 03:31:42
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,290,514.09	ADJUSTMENTS	0.00
COVERED CHARGES	2,269,506.34	CONTRACTUAL ALLOW	1,294,675.57
NON-COVERD CHARGES	21,007.75	TOTAL MEDICAID LIAB	974,830.77
		LESS: COB	974,830.77
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 85

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	187		0	218,977.00		11,033.00
ROUTINE NURSERY	68		0	89,938.00		4,775.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	255		0	308,915.00		15,808.00
SPECIAL CARE SERVICES						
CCU	29		0	66,555.00		0.00
ICU	24		0	69,840.00		0.00
NICU	4		0	12,500.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	57		0	148,895.00		0.00
TOTAL ACCOMODATIONS	312		0	457,810.00		15,808.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	175,617.25	0.00	OTHER LAB	15,130.00	0.00
MED/SURG SUPPLY	76,951.74	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	207,520.00	0.00	EDUCATION & TRAINING	7,998.00	0.00
RADIOLOGY-DIAGNOSTIC	17,010.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	82,288.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,147.03	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,258.00	0.00	MRI SERVICES	15,639.00	0.00
IV THERAPY	13,817.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	205,715.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	358,445.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	114,081.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	61,286.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	50,759.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	70,841.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	5,199.75
LABORATORY PATHOLOGIC	10,274.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,934.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,990.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	119,760.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,441.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	85,597.16	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	16,955.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,882.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,948.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	22,024.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	49,000.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,388.16	0.00			
			TOTAL ANCILLARY	1,811,696.34	5,199.75
			TOTAL ACCOMODATIONS	457,810.00	15,808.00
			TOTAL CHARGES	2,269,506.34	21,007.75

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

Run Date: 08/24/2017
Run Time: 03:31:44
Page: 6

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	36,370,937.51	ADJUSTMENTS	389,721.72
COVERED CHARGES	32,485,808.11	CONTRACTUAL ALLOW	28,259,651.60
NON-COVERD CHARGES	3,885,129.40	TOTAL MEDICAID LIAB	4,226,156.51
		LESS: COB	88,469.49
		LESS: COPAYMENT	8,870.10
		REIMBURSEMENT	4,128,816.92
		ALL OTHER	3,569,515.74
		FEE SCHEDULE-LAB	368,528.16
		INJECTABLE DRUGS	190,773.02
		TOTAL NUMBER OF CLAIMS	9,824

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	660,196.12	30,147.75	OTHER LAB	708,231.00	574.00
MED/SURG SUPPLY	595,916.42	153,914.96	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	646.00	EDUCATION & TRAINING	0.00	443.00
RADIOLOGY-DIAGNOSTIC	1,679,432.00	3,422.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,010,375.00	702,478.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	143,954.00	51,383.01	FEE SCHEDULE LAB	4,850,871.68	243,776.23
EKG/ECG	476,631.00	10,281.00	MRI SERVICES	1,088,662.00	154,057.00
IV THERAPY	1,578,675.00	5,722.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,593,825.00	311,483.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	190,149.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	120,789.00	92,460.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	908,288.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,581,135.00	5,354.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	612,445.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	981.75
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,085,637.44	378,011.09
RADIOLOGY THERAPEUTIC	1,018,046.00	323,229.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	49,290.00	22,247.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	31,792.00	13,415.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	77,844.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	344,476.00	20,042.00	TRAUMA RESPONSE	0.00	44,720.00
PSYCHIATRIC SERVICES	59,760.00	140,454.00	IMPL DEV CHARGE PATIENTS	72,403.85	122,716.25
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,788.00
OTHER IMAGING SERVICE	1,095,818.00	353,308.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	143,138.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	504,666.00	215,406.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	680,401.00	396,078.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	118,058.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	482,746.60	7,747.36			
			TOTAL ANCILLARY	32,485,808.11	3,885,129.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	32,485,808.11	3,885,129.40

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

Run Date: 08/24/2017
Run Time: 03:31:44
Page: 8

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5916064001321	12/04/15 - 12/04/15	03/07/16	0.00	2,788.00	0.00	0.00	0.00
TOTAL				0.00	2,788.00	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: 08/24/2017
Run Time: 03:32:36
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	886,906.05	ADJUSTMENTS	0.00
COVERED CHARGES	730,796.06	CONTRACTUAL ALLOW	434,838.23
NON-COVERD CHARGES	156,109.99	TOTAL MEDICAID LIAB	295,957.83
		LESS: COB	295,787.30
		LESS: COPAYMENT	170.53
		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

WELLSTAR KENNESTONE HOSPITAL PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
 677 CHURCH ST NE 000001119A SERVICE DATES 07/01/15 THROUGH 06/30/16
 MARIETTA,GA 30060-1101 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,584.28	2,999.68	OTHER LAB	25,866.00	0.00
MED/SURG SUPPLY	21,011.76	2,657.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,368.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	34,178.00	31,980.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	98,118.79	3,579.42
EKG/ECG	4,207.00	447.00	MRI SERVICES	33,078.00	15,323.00
IV THERAPY	29,554.00	129.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	72,437.00	40,549.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	14,172.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,761.00	1,888.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	83,440.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	113,005.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	51,891.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	25,853.89	2,190.24
RADIOLOGY THERAPEUTIC	3,243.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,040.00	222.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	555.00	555.00	IMPL DEV CHARGE PATIENTS	124.44	13,434.32
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	42,380.00	20,566.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	12,315.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,131.00	6,576.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	10,782.00	9,193.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,699.90	3,820.73			
			TOTAL ANCILLARY	730,796.06	156,109.99
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	730,796.06	156,109.99

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,413,368.87	ADJUSTMENTS	905.61
COVERED CHARGES	1,304,321.87	CONTRACTUAL ALLOW	1,271,373.21
NON-COVERD CHARGES	109,047.00	TOTAL MEDICAID LIAB	32,948.66
		LESS: COB	0.00
		LESS: COPAYMENT	924.52
		REIMBURSEMENT	32,024.14
		TOTAL NUMBER OF CLAIMS	589

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

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

Run Date: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,079.50	722.00	OTHER LAB	57,739.00	0.00
MED/SURG SUPPLY	2,324.68	561.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	87,051.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	163,622.00	35,242.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	230,143.00	13,192.00
EKG/ECG	11,175.00	0.00	MRI SERVICES	0.00	4,550.00
IV THERAPY	68,021.00	1,021.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,917.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,805.00	3,776.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,136.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	597,931.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,187.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,558.75	4,250.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	412.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	6,870.00	14,985.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	42,376.00	30,748.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	973.94	0.00			
			TOTAL ANCILLARY	1,304,321.87	109,047.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,304,321.87	109,047.00

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

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

Run Date: 08/24/2017
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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	07/01/15	THROUGH	06/30/16
ADMISSION DATES	00/00/00	THROUGH	00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	90,789.50	ADJUSTMENTS	0.00
COVERED CHARGES	80,797.50	CONTRACTUAL ALLOW	61,095.55
NON-COVERD CHARGES	9,992.00	TOTAL MEDICAID LIAB	19,701.95
		LESS: COB	19,674.95
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	0.00
TOTAL NUMBER OF CLAIMS			20

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

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

Run Date: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	870.50	300.00	OTHER LAB	6,411.00	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	1,760.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,386.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	21,921.00	2,079.00
EKG/ECG	894.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,697.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	814.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,262.00	0.00	SPECIAL SERVICES	0.00	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	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	1,110.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,691.00	6,488.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	80,797.50	9,992.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	80,797.50	9,992.00

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,633,027.00	ADJUSTMENTS	60,991.54
COVERED CHARGES	3,569,718.06	CONTRACTUAL ALLOW	3,211,572.19
NON-COVERD CHARGES	63,308.94	TOTAL MEDICAID LIAB	358,145.87
		LESS: COB	7,847.84
		LESS: COPAYMENT	762.00
		REIMBURSEMENT	349,536.03

TOTAL NUMBER OF CLAIMS 64

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,329.50	1,635.00	OTHER LAB	264.00	0.00
MED/SURG SUPPLY	87,334.73	472.44	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	568.00	486.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	338.00	FEE SCHEDULE LAB	20,968.00	0.00
EKG/ECG	447.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	96,808.00	547.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	202,428.00	2.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	233.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	26,224.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,727.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,525,321.75	4,420.50
RADIOLOGY THERAPEUTIC	1,334,044.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,044.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,891.00	111.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	199,473.37	666.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	805.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,600.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	24,907.00	54,631.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,466.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,834.71	0.00			
			TOTAL ANCILLARY	3,569,718.06	63,308.94
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,569,718.06	63,308.94

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: 08/24/2017
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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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
 Run Time: 02:57:23
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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 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	33,400,402.83	ADJUSTMENTS	1,455,511.27
COVERED CHARGES	32,804,748.98	CONTRACTUAL ALLOW	27,149,434.23
NON-COVERD CHARGES	595,653.85	TOTAL MEDICAID LIAB	5,655,314.75
		LESS: COB	79,063.94
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,576,250.81

TOTAL NUMBER OF ADMISSIONS 692

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,872		2	1,748,581.00		141,441.00
ROUTINE NURSERY	143		0	95,036.00		987.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,015		2	1,843,617.00		142,428.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	721		0	1,742,190.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	721		0	1,742,190.00		0.00
TOTAL ACCOMODATIONS	2,736		2	3,585,807.00		142,428.00

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 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,202,032.50	0.00	OTHER LAB	147,626.25	0.00
MED/SURG SUPPLY	1,540,162.55	1,022.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,178,268.42	40.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	709,503.05	0.00	OTHER THERAPEUTIC SVC	0.00	29,449.00
CT SCAN	1,352,717.00	280,455.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	317,037.59	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	267,845.00	0.00	MRI SERVICES	270,553.00	0.00
IV THERAPY	2,389.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,267,946.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	319,646.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,466,173.75	1,063.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	192,861.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	82,024.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	964,691.00	369.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	311,754.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	42,606.00
LABORATORY PATHOLOGIC	62,040.54	0.00	INJECTABLE DRUGS	7,635,145.45	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	213,423.46	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	36,955.70	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	280,811.00	2,558.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	9,839.00	540.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	659,553.70	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	178,208.25	6,668.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	70,921.70	88,454.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	261,730.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,992,328.25	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	36,117.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	188,637.32	0.00			
			TOTAL ANCILLARY	29,218,941.98	453,225.85
			TOTAL ACCOMODATIONS	3,585,807.00	142,428.00
			TOTAL CHARGES	32,804,748.98	595,653.85

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

FAIRVIEW PARK HOSPITAL
 200 INDUSTRIAL BLVD
 DUBLIN,GA 31021-2981

PROVIDER NUMBER
 000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	393,646.38	ADJUSTMENTS	0.00
COVERED CHARGES	387,900.38	CONTRACTUAL ALLOW	254,596.07
NON-COVERD CHARGES	5,746.00	TOTAL MEDICAID LIAB	133,304.31
		LESS: COB	133,304.31
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 19

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	44		0	43,426.00		1,318.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	44		0	43,426.00		1,318.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	44		0	43,426.00		1,318.00

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 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,946.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	20,561.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	34,724.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,173.25	0.00	OTHER THERAPEUTIC SVC	0.00	364.00
CT SCAN	3,719.00	4,064.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	765.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	524.00	0.00	MRI SERVICES	4,602.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	39,094.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	88,892.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,125.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,982.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,716.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	58,268.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,215.25	0.00	INJECTABLE DRUGS	34,592.48	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,096.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,347.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,129.00	0.00			
			TOTAL ANCILLARY	344,474.38	4,428.00
			TOTAL ACCOMODATIONS	43,426.00	1,318.00
			TOTAL CHARGES	387,900.38	5,746.00

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: 08/24/2017
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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 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,907,210.55	ADJUSTMENTS	97,071.23
COVERED CHARGES	20,515,433.20	CONTRACTUAL ALLOW	18,866,550.67
NON-COVERD CHARGES	1,391,777.35	TOTAL MEDICAID LIAB	1,648,882.53
		LESS: COB	2,231.92
		LESS: COPAYMENT	4,279.93
		REIMBURSEMENT	1,642,370.68
		ALL OTHER	1,438,880.39
		FEE SCHEDULE-LAB	177,989.86
		INJECTABLE DRUGS	25,500.43

TOTAL NUMBER OF CLAIMS 5,252

FAIRVIEW PARK HOSPITAL
 200 INDUSTRIAL BLVD
 DUBLIN,GA 31021-2981

PROVIDER NUMBER
 000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	386,278.04	255.75	OTHER LAB	154,011.50	2,074.25
MED/SURG SUPPLY	935,518.25	62,567.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	12,701.75	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,181,821.00	2,854.25	OTHER THERAPEUTIC SVC	0.00	350.00
CT SCAN	3,324,302.90	232,221.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	164,928.00	14,845.50	FEE SCHEDULE LAB	4,677,904.59	337,553.50
EKG/ECG	367,039.00	2,620.00	MRI SERVICES	271,348.00	20,152.00
IV THERAPY	405,985.00	908.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,981,324.55	232,779.70	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	76,346.00	2,874.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	129,066.50	21,072.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	542,241.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	359,809.18	44,183.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,058,361.00	7,400.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	239,526.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	766.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	338,946.01	151,995.15
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	37,222.75	2,903.25	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,358.75	1,650.25	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,762.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	15,383.00	6,412.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	203,237.40	16,542.70
LITHOTRIPSY	81,285.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	556,385.00	32,812.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	20,871.00	22,568.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	213,552.00	47,892.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	428,797.00	100,067.25			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	230,078.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	128,506.78	7,993.00			
			TOTAL ANCILLARY	20,515,433.20	1,391,777.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	20,515,433.20	1,391,777.35

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

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	609,545.65	ADJUSTMENTS	0.00
COVERED CHARGES	461,281.65	CONTRACTUAL ALLOW	299,490.84
NON-COVERD CHARGES	148,264.00	TOTAL MEDICAID LIAB	161,790.81
		LESS: COB	161,736.44
		LESS: COPAYMENT	54.37
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 92

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 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,023.50	0.00	OTHER LAB	4,371.00	0.00
MED/SURG SUPPLY	40,688.60	1,288.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,160.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	46,551.00	28,414.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	106,264.75	5,136.50
EKG/ECG	8,930.00	0.00	MRI SERVICES	0.00	4,184.00
IV THERAPY	4,507.00	353.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	48,076.00	61,283.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,537.00	872.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	814.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	30,877.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	3,785.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	65,612.00	821.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,126.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,169.75	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	344.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	9,361.30	0.00
LITHOTRIPSY	27,095.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,936.25	20,914.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,833.00	7,469.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,987.00	13,252.00			
AMBULATORY SURGERY	0.00	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	461,281.65	148,264.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	461,281.65	148,264.00

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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FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,090,809.31	ADJUSTMENTS	759.16
COVERED CHARGES	1,034,595.44	CONTRACTUAL ALLOW	1,003,157.16
NON-COVERD CHARGES	56,213.87	TOTAL MEDICAID LIAB	31,438.28
		LESS: COB	0.00
		LESS: COPAYMENT	1,026.00
		REIMBURSEMENT	30,412.28
		TOTAL NUMBER OF CLAIMS	562

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 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,352.75	0.00	OTHER LAB	2,560.00	0.00
MED/SURG SUPPLY	10,142.40	146.10	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	781.75	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	72,784.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	134,840.00	17,456.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	280,390.25	31,570.25
EKG/ECG	16,332.00	0.00	MRI SERVICES	5,978.00	0.00
IV THERAPY	31,363.00	164.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,356.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,764.25	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	442,923.00	790.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,982.75	2,866.27
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	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,631.25	1,546.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,195.04	893.50			
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	1,034,595.44	56,213.87
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,034,595.44	56,213.87

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: 08/24/2017
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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 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,038.80	ADJUSTMENTS	0.00
COVERED CHARGES	12,038.80	CONTRACTUAL ALLOW	6,401.31
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	5,637.49
		LESS: COB	5,628.49
		LESS: COPAYMENT	9.00
		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: 08/24/2017
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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 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	255.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	164.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,114.25	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	3,583.50	0.00
EKG/ECG	476.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	689.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,637.00	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	119.75	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	12,038.80	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,038.80	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

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	897,457.06	ADJUSTMENTS	11,081.46
COVERED CHARGES	819,423.08	CONTRACTUAL ALLOW	763,584.10
NON-COVERD CHARGES	78,033.98	TOTAL MEDICAID LIAB	55,838.98
		LESS: COB	6,096.75
		LESS: COPAYMENT	45.00
		REIMBURSEMENT	49,697.23
		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: 08/24/2017
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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 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,236.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	130,326.50	13,294.10	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,134.25	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	30,203.00	40.50
EKG/ECG	5,000.00	1,000.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	187,712.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	722.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	21,793.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,550.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,014.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,788.58	5,220.98
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	123,958.00	39,923.40
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	267,835.00	18,555.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,150.00	0.00			
			TOTAL ANCILLARY	819,423.08	78,033.98
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	819,423.08	78,033.98

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: 08/24/2017
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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	05/01/15	THROUGH	04/30/16
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: 08/24/2017
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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 12/01/15 THROUGH 11/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,538,601.67	ADJUSTMENTS	45,812.58
COVERED CHARGES	1,521,961.67	CONTRACTUAL ALLOW	1,045,372.76
NON-COVERD CHARGES	16,640.00	TOTAL MEDICAID LIAB	476,588.91
		LESS: COB	12,803.54
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	463,785.37

TOTAL NUMBER OF ADMISSIONS 104

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	219		0	209,145.00		13,579.00
ROUTINE NURSERY	66		0	29,311.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	285		0	238,456.00		13,579.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	9		0	13,698.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	13,698.00		0.00
TOTAL ACCOMODATIONS	294		0	252,154.00		13,579.00

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 12/01/15 THROUGH 11/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	142,552.80	0.00	OTHER LAB	13,419.00	0.00
MED/SURG SUPPLY	68,172.87	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	245,177.06	0.00	EDUCATION & TRAINING	2,394.00	0.00
RADIOLOGY-DIAGNOSTIC	17,178.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	74,493.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,675.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	7,450.00	0.00	MRI SERVICES	7,845.00	0.00
IV THERAPY	36,673.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	110,703.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	24,468.00	399.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	45,250.44	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	21,272.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	53,470.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,120.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	292,605.50	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	351.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,354.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	23,862.00	1,022.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	11,007.00	0.00			
AUDIOLOGY	501.00	1,414.00			
CARDIOLOGY	18,385.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	35,429.00	226.00			
			TOTAL ANCILLARY	1,269,807.67	3,061.00
			TOTAL ACCOMODATIONS	252,154.00	13,579.00
			TOTAL CHARGES	1,521,961.67	16,640.00

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

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

Run Date: 08/24/2017
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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 12/01/15 THROUGH 11/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	42,758.48	ADJUSTMENTS	0.00
COVERED CHARGES	41,683.48	CONTRACTUAL ALLOW	29,051.18
NON-COVERD CHARGES	1,075.00	TOTAL MEDICAID LIAB	12,632.30
		LESS: COB	12,632.30
		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	6,685.00		1,075.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	7		0	6,685.00		1,075.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	7		0	6,685.00		1,075.00

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 12/01/15 THROUGH 11/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,683.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,686.48	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,475.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	956.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	944.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,532.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,120.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,078.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	312.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,300.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,614.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	298.00	0.00			
			TOTAL ANCILLARY	34,998.48	0.00
			TOTAL ACCOMODATIONS	6,685.00	1,075.00
			TOTAL CHARGES	41,683.48	1,075.00

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: 08/24/2017
Run Time: 03:33:34
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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 12/01/15 THROUGH 11/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,180,370.72	ADJUSTMENTS	205,111.32
COVERED CHARGES	4,888,871.13	CONTRACTUAL ALLOW	3,943,623.12
NON-COVERD CHARGES	291,499.59	TOTAL MEDICAID LIAB	945,248.01
		LESS: COB	6,126.86
		LESS: COPAYMENT	2,064.70
		REIMBURSEMENT	937,056.45
		ALL OTHER	849,606.57
		FEE SCHEDULE-LAB	82,783.84
		INJECTABLE DRUGS	4,666.04
		TOTAL NUMBER OF CLAIMS	2,741

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 12/01/15 THROUGH 11/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	270,998.86	18,755.00	OTHER LAB	54,516.00	0.00
MED/SURG SUPPLY	109,095.15	667.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	3,059.00
RADIOLOGY-DIAGNOSTIC	243,976.20	6,351.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	701,845.00	64,096.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,260.00	3,491.00	FEE SCHEDULE LAB	1,050,018.73	20,159.96
EKG/ECG	51,303.00	1,937.00	MRI SERVICES	98,514.00	10,587.00
IV THERAPY	189,894.00	26,060.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	220,712.00	22,504.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	11,451.00	0.00	REHAB THERAPY	0.00	596.00
RESPIRATORY SERVICES	40,855.75	14,665.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	51,708.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,042,708.00	27,043.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,695.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	238,440.00	17,732.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	343.88	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	117.00	585.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,481.44	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	378.00
OTHER IMAGING SERVICE	236,417.00	26,366.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,030.00	2,044.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	70,031.00	3,541.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	34,433.00	11,118.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	133,371.00	9,420.00			
			TOTAL ANCILLARY	4,888,871.13	291,499.59
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,888,871.13	291,499.59

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

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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 12/01/15 THROUGH 11/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016120069554	12/08/15 - 12/08/15	05/02/16	0.00	189.00	0.00	0.00	0.00
948	2016120069554	12/10/15 - 12/10/15	05/02/16	0.00	189.00	0.00	0.00	0.00
TOTAL				0.00	378.00	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: 08/24/2017
Run Time: 03:33:54
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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 12/01/15 THROUGH 11/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	41,914.12	ADJUSTMENTS	0.00
COVERED CHARGES	33,080.52	CONTRACTUAL ALLOW	20,210.66
NON-COVERD CHARGES	8,833.60	TOTAL MEDICAID LIAB	12,869.86
		LESS: COB	12,857.86
		LESS: COPAYMENT	12.00
		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

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 12/01/15 THROUGH 11/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	979.80	572.00	OTHER LAB	895.00	0.00
MED/SURG SUPPLY	519.72	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	985.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,270.00	4,567.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,452.00	206.60
EKG/ECG	298.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	145.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	1,834.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	302.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,209.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,338.00	803.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,000.00	52.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,687.00	799.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	33,080.52	8,833.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	33,080.52	8,833.60

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: 08/24/2017
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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 12/01/15 THROUGH 11/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	272,516.24	ADJUSTMENTS	141.00
COVERED CHARGES	266,103.24	CONTRACTUAL ALLOW	251,303.24
NON-COVERD CHARGES	6,413.00	TOTAL MEDICAID LIAB	14,800.00
		LESS: COB	29.19
		LESS: COPAYMENT	479.48
		REIMBURSEMENT	14,291.33
		TOTAL NUMBER OF CLAIMS	296

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 12/01/15 THROUGH 11/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,533.00	436.00	OTHER LAB	1,291.00	0.00
MED/SURG SUPPLY	2,929.24	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,405.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	34,133.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	54,928.00	1,999.00
EKG/ECG	1,937.00	149.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,959.00	1,963.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	151.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	134,858.00	817.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,783.00	155.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,196.00	799.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	95.00			
			TOTAL ANCILLARY	266,103.24	6,413.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	266,103.24	6,413.00

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

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 12/01/15 THROUGH 11/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,788.00	ADJUSTMENTS	0.00
COVERED CHARGES	8,748.00	CONTRACTUAL ALLOW	6,365.48
NON-COVERD CHARGES	40.00	TOTAL MEDICAID LIAB	2,382.52
		LESS: COB	2,376.52
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	9

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 12/01/15 THROUGH 11/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	176.00	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	3,906.00	40.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,666.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	8,748.00	40.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,748.00	40.00

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 12/01/15 THROUGH 11/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	171,248.48	ADJUSTMENTS	19,813.64
COVERED CHARGES	164,765.48	CONTRACTUAL ALLOW	139,983.43
NON-COVERD CHARGES	6,483.00	TOTAL MEDICAID LIAB	24,782.05
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	24,770.05

TOTAL NUMBER OF CLAIMS 5

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 12/01/15 THROUGH 11/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,878.00	354.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	39,267.48	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	511.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,134.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,348.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,348.00	4,367.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	58,033.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	151.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,000.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,962.00	102.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,560.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,449.00	621.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	720.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	799.00	799.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,605.00	240.00			
			TOTAL ANCILLARY	164,765.48	6,483.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	164,765.48	6,483.00

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: 08/24/2017
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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	12/01/15	THROUGH	11/30/16
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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	113,843.00	ADJUSTMENTS	0.00
COVERED CHARGES	109,190.00	CONTRACTUAL ALLOW	59,111.89
NON-COVERD CHARGES	4,653.00	TOTAL MEDICAID LIAB	50,078.11
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	50,078.11

TOTAL NUMBER OF ADMISSIONS 10

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	36		0	14,510.75		906.25
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	36		0	14,510.75		906.25
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	36		0	14,510.75		906.25

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,650.25	0.00	OTHER LAB	441.00	0.00
MED/SURG SUPPLY	3,940.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	15,980.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,062.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,635.75	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	177.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,457.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,712.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	30,389.75	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	85.50	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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,147.00	3,746.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	94,679.25	3,746.75
			TOTAL ACCOMODATIONS	14,510.75	906.25
			TOTAL CHARGES	109,190.00	4,653.00

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

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

Run Date: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	629,491.69	ADJUSTMENTS	18,800.52
COVERED CHARGES	582,433.37	CONTRACTUAL ALLOW	352,828.25
NON-COVERD CHARGES	47,058.32	TOTAL MEDICAID LIAB	229,605.12
		LESS: COB	74.74
		LESS: COPAYMENT	261.39
		REIMBURSEMENT	229,268.99
		ALL OTHER	206,030.17
		FEE SCHEDULE-LAB	21,729.49
		INJECTABLE DRUGS	1,509.33

TOTAL NUMBER OF CLAIMS 735

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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,026.22	235.72	OTHER LAB	4,021.25	0.00
MED/SURG SUPPLY	17,162.25	140.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	32,857.25	704.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	83,067.50	27,381.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	491.25	1,788.75	FEE SCHEDULE LAB	120,634.00	8,756.00
EKG/ECG	9,571.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	26,222.75	88.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	183,412.25	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	24,787.15	3,084.35
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	893.75	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	441.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	603.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,136.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,074.75	3,148.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,305.75	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	39,907.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,152.00	396.00			
			TOTAL ANCILLARY	582,433.37	47,058.32
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	582,433.37	47,058.32

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,
116 W THIGPEN AVENUE
LAKELAND,GA 31635-1006

PROVIDER NUMBER
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	413.75	ADJUSTMENTS	0.00
COVERED CHARGES	413.75	CONTRACTUAL ALLOW	82.75
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	331.00
		LESS: COB	331.00
		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

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

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

Run Date: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 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	13.25	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	0.00	0.00
EKG/ECG	177.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	223.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	413.75	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	413.75	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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	60,748.03	ADJUSTMENTS	47.00
COVERED CHARGES	60,004.58	CONTRACTUAL ALLOW	54,654.58
NON-COVERD CHARGES	743.45	TOTAL MEDICAID LIAB	5,350.00
		LESS: COB	0.00
		LESS: COPAYMENT	146.65
		REIMBURSEMENT	5,203.35
		TOTAL NUMBER OF CLAIMS	107

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,003.28	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,660.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,869.25	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	7,819.00	433.50
EKG/ECG	531.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,548.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	41,973.25	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	2,600.05	309.95
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	60,004.58	743.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	60,004.58	743.45

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: 08/24/2017
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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	10/01/15	THROUGH	09/30/16
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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	28,239.98	ADJUSTMENTS	5,049.93
COVERED CHARGES	27,826.98	CONTRACTUAL ALLOW	22,777.05
NON-COVERD CHARGES	413.00	TOTAL MEDICAID LIAB	5,049.93
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,049.93

TOTAL NUMBER OF CLAIMS 1

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,892.73	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	106.50	18.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,107.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,910.75	309.50
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	14,769.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	893.50	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	3,009.50	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	85.50	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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,137.25	0.00			
			TOTAL ANCILLARY	27,826.98	413.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	27,826.98	413.00

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: 08/24/2017
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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	10/01/15	THROUGH	09/30/16
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: 08/24/2017
 Run Time: 03:34:09
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,045,043.03	ADJUSTMENTS	0.00
COVERED CHARGES	1,043,032.03	CONTRACTUAL ALLOW	679,801.38
NON-COVERD CHARGES	2,011.00	TOTAL MEDICAID LIAB	363,230.65
		LESS: COB	802.79
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	362,427.86

TOTAL NUMBER OF ADMISSIONS 43

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	147		0	83,604.00		1,656.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	147		0	83,604.00		1,656.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	30		0	29,190.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	29,190.00		0.00
TOTAL ACCOMODATIONS	177		0	112,794.00		1,656.00

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 01/01/16 THROUGH 12/31/16
 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	223,813.40	0.00	OTHER LAB	3,588.00	0.00
MED/SURG SUPPLY	250,777.03	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	47,895.97	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,850.00	0.00	OTHER THERAPEUTIC SVC	0.00	355.00
CT SCAN	29,920.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	19,700.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,620.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,504.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	80,770.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	28,217.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,359.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	39,786.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	15,836.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	401.28	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,407.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,534.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	378.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	129,635.35	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,001.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,214.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,418.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,613.00	0.00			
			TOTAL ANCILLARY	930,238.03	355.00
			TOTAL ACCOMODATIONS	112,794.00	1,656.00
			TOTAL CHARGES	1,043,032.03	2,011.00

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

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 01/01/16 THROUGH 12/31/16
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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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,068,502.47	ADJUSTMENTS	77,869.06
COVERED CHARGES	3,889,443.34	CONTRACTUAL ALLOW	2,977,347.89
NON-COVERD CHARGES	179,059.13	TOTAL MEDICAID LIAB	912,095.45
		LESS: COB	4,531.95
		LESS: COPAYMENT	1,353.00
		REIMBURSEMENT	906,210.50
		ALL OTHER	853,667.76
		FEE SCHEDULE-LAB	48,099.16
		INJECTABLE DRUGS	4,443.58
		TOTAL NUMBER OF CLAIMS	2,024

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	199,699.39	0.00	OTHER LAB	93,929.00	0.00
MED/SURG SUPPLY	271,364.26	1,080.15	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	39.00	179.00
RADIOLOGY-DIAGNOSTIC	191,367.00	1,790.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	576,060.00	62,675.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	441.00	FEE SCHEDULE LAB	356,034.97	5,000.46
EKG/ECG	50,031.00	1,572.00	MRI SERVICES	0.00	0.00
IV THERAPY	222,536.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	322,021.00	53,742.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	23,285.00	8,141.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	35,227.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,182,881.00	786.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	80,499.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	154,638.28	22,527.52
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	127.00	3,780.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	33,360.44	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	56,287.00	4,274.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,248.00	588.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	11,963.00	10,254.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	17,846.00	2,229.00			
			TOTAL ANCILLARY	3,889,443.34	179,059.13
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,889,443.34	179,059.13

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

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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,805.17	ADJUSTMENTS	0.00
COVERED CHARGES	27,077.17	CONTRACTUAL ALLOW	9,914.02
NON-COVERD CHARGES	728.00	TOTAL MEDICAID LIAB	17,163.15
		LESS: COB	17,151.15
		LESS: COPAYMENT	12.00
		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

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 01/01/16 THROUGH 12/31/16
 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	1,008.49	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,695.68	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,923.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,097.08	140.00
EKG/ECG	786.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,425.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,380.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	333.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,947.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	599.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,190.92	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	692.00	588.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	27,077.17	728.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	27,077.17	728.00

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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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	117,447.35	ADJUSTMENTS	108.88
COVERED CHARGES	116,504.45	CONTRACTUAL ALLOW	109,679.77
NON-COVERD CHARGES	942.90	TOTAL MEDICAID LIAB	6,824.68
		LESS: COB	0.00
		LESS: COPAYMENT	180.00
		REIMBURSEMENT	6,644.68
		TOTAL NUMBER OF CLAIMS	122

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 01/01/16 THROUGH 12/31/16
 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	2,407.28	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,533.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,419.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,918.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	15,962.60	120.52
EKG/ECG	262.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,235.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	360.00	121.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	74,149.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,258.57	701.38
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	116,504.45	942.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	116,504.45	942.90

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: 08/24/2017
Run Time: 03:34:30
Page: 10

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 01/01/16 THROUGH 12/31/16
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: 08/24/2017
Run Time: 03:34:31
Page: 11

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	37,970.05	ADJUSTMENTS	0.00
COVERED CHARGES	37,130.73	CONTRACTUAL ALLOW	26,040.27
NON-COVERD CHARGES	839.32	TOTAL MEDICAID LIAB	11,090.46
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	11,084.46

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 01/01/16 THROUGH 12/31/16
 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	3,284.10	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,639.96	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	514.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,776.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	245.00	FEE SCHEDULE LAB	794.52	0.00
EKG/ECG	262.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,593.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,940.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	599.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,500.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	859.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,047.59	372.32
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	222.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,745.56	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	576.00	0.00			
			TOTAL ANCILLARY	37,130.73	839.32
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	37,130.73	839.32

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: 08/24/2017
Run Time: 03:34:31
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER
000001185A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/16	THROUGH	12/31/16
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: 08/24/2017
 Run Time: 03:48:25
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	54,398,561.87	ADJUSTMENTS	6,158,575.88
COVERED CHARGES	52,242,696.33	CONTRACTUAL ALLOW	34,930,365.59
NON-COVERD CHARGES	2,155,865.54	TOTAL MEDICAID LIAB	17,312,330.74
		LESS: COB	139,770.35
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	17,172,560.39

TOTAL NUMBER OF ADMISSIONS 1,478

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7,207		2	4,523,992.00		212,088.00
ROUTINE NURSERY	959		0	629,850.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	8,166		2	5,153,842.00		212,088.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,426		0	2,383,096.00		10,080.00
NICU	197		0	330,960.00		0.00
PED ICU	126		0	211,680.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,749		0	2,925,736.00		10,080.00
TOTAL ACCOMODATIONS	9,915		2	8,079,578.00		222,168.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,691,058.54	22,097.31	OTHER LAB	179,413.14	3,101.52
MED/SURG SUPPLY	3,821,620.47	38,498.02	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,964,979.40	122,296.26	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	968,840.30	5,517.47	OTHER THERAPEUTIC SVC	0.00	117,682.24
CT SCAN	1,497,451.26	645,177.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	278,292.73	6,354.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	180,771.00	779.25	MRI SERVICES	780,439.33	5,356.87
IV THERAPY	242,537.00	5,049.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,534,202.58	8,588.28	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,049,169.74	3,419.19	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,607,040.17	74,478.35	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	257,027.76	311.84	AMBULANCE	0.00	56,070.56
GI SERVICES	539,600.00	3,000.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,453,394.70	3,357.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	471,490.37	0.00	DRUG-SPECIFIC/HOME IV	0.00	2,508.60
LABORATORY PATHOLOGIC	116,719.06	200.40	INJECTABLE DRUGS	9,992,491.42	92,647.88
RADIOLOGY THERAPEUTIC	221,479.30	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	134,248.83	1,875.96	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	67,953.68	1,517.15	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	228,130.56	15,456.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	9,605.67	13,157.29	TRAUMA RESPONSE	0.00	25,000.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,027,305.97	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	418,540.92	734.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,008,217.12	655,920.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	130,751.58	74.75			
AUDIOLOGY	70,070.75	0.00			
CARDIOLOGY	1,063,523.88	2,692.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	82,247.80	779.10			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	74,503.30	0.00			
			TOTAL ANCILLARY	44,163,118.33	1,933,697.54
			TOTAL ACCOMODATIONS	8,079,578.00	222,168.00
			TOTAL CHARGES	52,242,696.33	2,155,865.54

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

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

Run Date: 08/24/2017
 Run Time: 03:48:39
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	940,249.17	ADJUSTMENTS	0.00
COVERED CHARGES	923,575.01	CONTRACTUAL ALLOW	584,101.16
NON-COVERD CHARGES	16,674.16	TOTAL MEDICAID LIAB	339,473.85
		LESS: COB	339,473.85
		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	106		0	67,204.00		1,080.00
ROUTINE NURSERY	31		0	25,050.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	137		0	92,254.00		1,080.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	1		0	1,680.00		0.00
PED ICU	2		0	3,360.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	5,040.00		0.00
TOTAL ACCOMODATIONS	140		0	97,294.00		1,080.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	51,422.30	0.00	OTHER LAB	1,674.26	0.00
MED/SURG SUPPLY	96,998.52	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	44,895.14	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,921.91	0.00	OTHER THERAPEUTIC SVC	0.00	3,500.56
CT SCAN	29,308.00	3,201.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,353.60	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,090.95	0.00	MRI SERVICES	3,306.00	0.00
IV THERAPY	2,754.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	34,479.71	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,143.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	119,021.15	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,447.36	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,000.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	24,502.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,265.54	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	134.40	0.00	INJECTABLE DRUGS	337,450.70	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	764.32	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	390.49	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	85.91	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	12,138.36	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,685.45	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,435.00	8,892.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,500.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	6,874.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	237.69	0.00			
			TOTAL ANCILLARY	826,281.01	15,594.16
			TOTAL ACCOMODATIONS	97,294.00	1,080.00
			TOTAL CHARGES	923,575.01	16,674.16

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: 08/24/2017
Run Time: 03:48:42
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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,325,386.33	ADJUSTMENTS	181,362.83
COVERED CHARGES	17,370,507.55	CONTRACTUAL ALLOW	11,757,103.76
NON-COVERD CHARGES	3,954,878.78	TOTAL MEDICAID LIAB	5,613,403.79
		LESS: COB	16,919.47
		LESS: COPAYMENT	23,511.22
		REIMBURSEMENT	5,572,973.10
		ALL OTHER	4,989,770.93
		FEE SCHEDULE-LAB	271,125.78
		INJECTABLE DRUGS	312,076.39

TOTAL NUMBER OF CLAIMS 13,878

MIDTOWN MEDICAL CENTER
 710 CENTER STREET
 COLUMBUS,GA 31902-1527

PROVIDER NUMBER
 000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	308,923.08	115.15	OTHER LAB	81,009.28	0.00
MED/SURG SUPPLY	236,055.00	6,984.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	6,101.82	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	725,411.63	15,482.49	OTHER THERAPEUTIC SVC	0.00	3,363.36
CT SCAN	1,220,086.34	406,042.65	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	37,136.48	6,354.96	FEE SCHEDULE LAB	2,462,374.11	130,845.20
EKG/ECG	168,454.25	0.00	MRI SERVICES	335,620.66	29,615.36
IV THERAPY	1,375,842.00	4,367.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	867,378.96	225,855.20	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	10,539.70	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	200,458.31	60,654.90	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	125,048.32	752.00	AMBULANCE	0.00	0.00
GI SERVICES	427,550.33	74,549.67	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,900,216.74	18,015.55	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	442,384.32	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,369,141.06	1,369,926.80
RADIOLOGY THERAPEUTIC	731,386.86	1,141,156.06	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,211.60	1,259.60	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,152.00	4,741.47	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	8,655.36	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	43.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	782,534.33	8,462.01	TRAUMA RESPONSE	0.00	5,000.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	75,342.66	660.10
LITHOTRIPSY	16,784.99	0.00	NO CC/INVALID REV CODE	0.00	77.28
OTHER IMAGING SERVICE	578,879.81	100,234.31			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	247,520.25	189,081.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	51,316.96	76,124.06			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	67,531.50	39,170.00			
AMBULATORY SURGERY	6,620.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	332,249.30	5,254.00			
ORGAN ACQUISITION	0.00	11,375.00			
TREATMENT/OBSERV. RM	181,303.72	4,602.42			
			TOTAL ANCILLARY	17,370,507.55	3,954,878.78
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,370,507.55	3,954,878.78

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015314020897	10/14/15 - 10/14/15	11/16/15	0.00	77.28	0.00	0.00	0.00
TOTAL				0.00	77.28	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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	402,417.72	ADJUSTMENTS	0.00
COVERED CHARGES	263,331.66	CONTRACTUAL ALLOW	138,431.80
NON-COVERD CHARGES	139,086.06	TOTAL MEDICAID LIAB	124,899.86
		LESS: COB	124,747.87
		LESS: COPAYMENT	151.99
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 141

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,072.35	0.00	OTHER LAB	1,772.02	0.00
MED/SURG SUPPLY	7,568.67	25.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,513.19	448.98	OTHER THERAPEUTIC SVC	0.00	1,885.00
CT SCAN	15,050.75	10,100.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	27,859.95	2,309.60
EKG/ECG	1,558.50	155.85	MRI SERVICES	3,111.79	16,137.30
IV THERAPY	18,848.00	100.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,556.39	14,557.71	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,742.89	5,227.34	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,535.76	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,500.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	47,809.25	1,412.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	17,240.85	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	32,915.35	76,735.45
RADIOLOGY THERAPEUTIC	8,261.39	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,410.00	204.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	16,784.99	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,555.48	2,778.58			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,488.00	2,223.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	280.00	3,689.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	6,801.10	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,094.99	1,096.50			
			TOTAL ANCILLARY	263,331.66	139,086.06
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	263,331.66	139,086.06

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	871,214.84	ADJUSTMENTS	429.52
COVERED CHARGES	824,248.49	CONTRACTUAL ALLOW	770,154.51
NON-COVERD CHARGES	46,966.35	TOTAL MEDICAID LIAB	54,093.98
		LESS: COB	52.58
		LESS: COPAYMENT	1,273.45
		REIMBURSEMENT	52,767.95
		TOTAL NUMBER OF CLAIMS	967

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,249.79	93.90	OTHER LAB	820.00	0.00
MED/SURG SUPPLY	2,060.24	138.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,401.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	35,718.98	270.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	27,927.35	19,463.65	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	131,581.13	7,471.27
EKG/ECG	9,195.15	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	51,279.00	200.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,570.37	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,986.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,356.00	470.40	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	511,013.65	387.45	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,891.15	11,305.50
RADIOLOGY THERAPEUTIC	1,714.07	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	315.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,566.62	4,497.18			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,997.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,695.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,311.99	1,268.00			
			TOTAL ANCILLARY	824,248.49	46,966.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	824,248.49	46,966.35

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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MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,478.99	ADJUSTMENTS	0.00
COVERED CHARGES	6,786.99	CONTRACTUAL ALLOW	4,050.46
NON-COVERD CHARGES	3,692.00	TOTAL MEDICAID LIAB	2,736.53
		LESS: COB	2,727.53
		LESS: COPAYMENT	9.00
		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

MIDTOWN MEDICAL CENTER
 710 CENTER STREET
 COLUMBUS,GA 31902-1527

PROVIDER NUMBER
 000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	60.80	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	516.50	0.00	OTHER THERAPEUTIC SVC	0.00	812.00
CT SCAN	0.00	2,585.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,352.49	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	4,847.20	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	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	6,786.99	3,692.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,786.99	3,692.00

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

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,043,010.41	ADJUSTMENTS	23,523.67
COVERED CHARGES	5,280,340.15	CONTRACTUAL ALLOW	4,202,704.11
NON-COVERD CHARGES	762,670.26	TOTAL MEDICAID LIAB	1,077,636.04
		LESS: COB	0.00
		LESS: COPAYMENT	2,152.73
		REIMBURSEMENT	1,075,483.31

TOTAL NUMBER OF CLAIMS 184

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	65,785.60	146.35	OTHER LAB	573.00	0.00
MED/SURG SUPPLY	251,074.31	2,057.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	157,632.44	8,547.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	31,191.55	14,069.40	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,622.56	FEE SCHEDULE LAB	82,593.28	2,764.27
EKG/ECG	2,181.90	0.00	MRI SERVICES	9,226.02	0.00
IV THERAPY	273,450.00	231.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	834,931.27	223,030.47	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,459.00	824.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	34,711.44	0.00	AMBULANCE	0.00	0.00
GI SERVICES	20,000.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,200.15	134.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	216,995.47	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,614,699.30	173,307.01
RADIOLOGY THERAPEUTIC	582,548.04	302,976.50	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	1,854.72	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	44,614.00	638.56	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	916,423.05	18,782.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,364.02	786.06			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	16,456.75	10,003.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	49,280.10	371.22			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	30,469.75	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	13,479.71	524.64			
			TOTAL ANCILLARY	5,280,340.15	762,670.26
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,280,340.15	762,670.26

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

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	186,108.08	ADJUSTMENTS	0.00
COVERED CHARGES	176,179.36	CONTRACTUAL ALLOW	49,563.74
NON-COVERD CHARGES	9,928.72	TOTAL MEDICAID LIAB	126,615.62
		LESS: COB	126,609.62
		LESS: COPAYMENT	6.00
		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

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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MIDTOWN MEDICAL CENTER
 710 CENTER STREET
 COLUMBUS,GA 31902-1527

PROVIDER NUMBER
 000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	356.10	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,530.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,618.72	9,928.72	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	923.68	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,288.36	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	157,462.50	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	176,179.36	9,928.72
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	176,179.36	9,928.72

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

MEDICAL CENTER, NAVICENT HEALTH (THE)
 777 HEMLOCK ST
 MACON,GA 31201-2102

PROVIDER NUMBER 000001207A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	154,874,784.98	ADJUSTMENTS	4,796,524.65
COVERED CHARGES	149,073,967.06	CONTRACTUAL ALLOW	111,969,853.31
NON-COVERD CHARGES	5,800,817.92	TOTAL MEDICAID LIAB	37,104,113.75
		LESS: COB	166,386.82
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	36,937,726.93

TOTAL NUMBER OF ADMISSIONS 2,987

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	14,701	8	11,225,833.00	1,001,071.00
ROUTINE NURSERY	1,103	13	2,973,360.00	177,876.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	15,804	21	14,199,193.00	1,178,947.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	3,962	0	9,413,163.00	175,285.00
NICU	1,494	0	7,992,900.00	0.00
PED ICU	924	0	2,663,274.00	11,552.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	6,380	0	20,069,337.00	186,837.00
TOTAL ACCOMODATIONS	22,184	21	34,268,530.00	1,365,784.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

MEDICAL CENTER, NAVICENT HEALTH (THE)
 777 HEMLOCK ST
 MACON,GA 31201-2102

PROVIDER NUMBER
 000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,590,713.03	401,581.75	OTHER LAB	800,905.00	7,995.00
MED/SURG SUPPLY	4,716,343.30	152,642.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	15,117,154.16	332,341.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,279,609.00	38,150.00	OTHER THERAPEUTIC SVC	0.00	9,826.00
CT SCAN	6,148,243.00	152,140.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	592,650.05	17,243.13	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	525,053.00	2,394.00	MRI SERVICES	2,560,184.00	8,524.00
IV THERAPY	647,002.00	9,070.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,725,657.00	213,610.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,347,093.00	4,750.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,493,066.00	411,609.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,551,527.00	27,404.00	AMBULANCE	0.00	0.00
GI SERVICES	21,510.00	3,585.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,768,053.00	15,130.28	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,026,627.00	1,316.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	206,455.00	1,177.00	INJECTABLE DRUGS	9,101,923.60	346,412.87
RADIOLOGY THERAPEUTIC	26,106.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	254,262.84	3,128.06	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	368,714.17	11,187.33	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,008,212.00	1,931,384.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	175.00	47,945.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	122,661.00	0.00	IMPL DEV CHARGE PATIENTS	6,396,158.91	4,760.00
LITHOTRIpsy	17,844.00	0.00	NO CC/INVALID REV CODE	0.00	7,953.00
OTHER IMAGING SERVICE	344,887.00	2,422.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,920,269.00	159,128.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	540,253.00	19,087.00			
AUDIOLOGY	0.00	23,262.00			
CARDIOLOGY	3,304,490.00	12,090.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	152,871.00	761.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,128,765.00	55,025.00			
			TOTAL ANCILLARY	114,805,437.06	4,435,033.92
			TOTAL ACCOMODATIONS	34,268,530.00	1,365,784.00
			TOTAL CHARGES	149,073,967.06	5,800,817.92

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

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2216250001335	05/01/16 - 06/02/16	09/12/16	0.00	7,953.00	0.00	0.00	0.00
TOTAL				0.00	7,953.00	0.00	0.00	0.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

MEDICAL CENTER, NAVICENT HEALTH (THE)
 777 HEMLOCK ST
 MACON,GA 31201-2102

PROVIDER NUMBER 000001207A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,993,198.38	ADJUSTMENTS	0.00
COVERED CHARGES	2,988,914.38	CONTRACTUAL ALLOW	1,852,541.60
NON-COVERD CHARGES	4,284.00	TOTAL MEDICAID LIAB	1,136,372.78
		LESS: COB	1,136,372.78
		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	135		0	105,702.00		3,783.00
ROUTINE NURSERY	99		0	472,091.00		78.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	234		0	577,793.00		3,861.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	38		0	105,511.00		0.00
NICU	47		0	251,450.00		0.00
PED ICU	37		0	106,856.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	463,817.00		0.00
TOTAL ACCOMODATIONS	356		0	1,041,610.00		3,861.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

MEDICAL CENTER, NAVICENT HEALTH (THE)
 777 HEMLOCK ST
 MACON,GA 31201-2102

PROVIDER NUMBER
 000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	427,367.83	0.00	OTHER LAB	18,483.00	0.00
MED/SURG SUPPLY	48,051.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	182,505.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	46,177.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	44,856.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,694.20	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,223.00	0.00	MRI SERVICES	27,682.00	0.00
IV THERAPY	4,283.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	119,178.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	74,163.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	398,484.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	29,824.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,671.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,306.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,659.00	0.00	INJECTABLE DRUGS	90,657.03	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,600.08	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	7,423.24	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	32,793.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	236,081.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,147.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	16,014.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,706.00	251.00			
AUDIOLOGY	0.00	172.00			
CARDIOLOGY	53,830.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,539.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	20,907.00	0.00			
			TOTAL ANCILLARY	1,947,304.38	423.00
			TOTAL ACCOMODATIONS	1,041,610.00	3,861.00
			TOTAL CHARGES	2,988,914.38	4,284.00

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 CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	47,986,875.79	ADJUSTMENTS	773,218.70
COVERED CHARGES	42,494,000.76	CONTRACTUAL ALLOW	33,539,233.96
NON-COVERD CHARGES	5,492,875.03	TOTAL MEDICAID LIAB	8,954,766.80
		LESS: COB	41,812.88
		LESS: COPAYMENT	28,104.60
		REIMBURSEMENT	8,884,849.32
		ALL OTHER	7,137,272.86
		FEE SCHEDULE-LAB	888,671.72
		INJECTABLE DRUGS	858,904.74

TOTAL NUMBER OF CLAIMS 24,115

MEDICAL CENTER, NAVICENT HEALTH (THE)
 777 HEMLOCK ST
 MACON,GA 31201-2102

PROVIDER NUMBER
 000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,001,176.16	65,798.07	OTHER LAB	303,525.00	259.00
MED/SURG SUPPLY	758,312.00	98,855.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	21,061.00	EDUCATION & TRAINING	0.00	160.00
RADIOLOGY-DIAGNOSTIC	1,930,612.00	300,824.00	OTHER THERAPEUTIC SVC	0.00	88,394.00
CT SCAN	3,526,443.00	504,566.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	29,606.00	18,038.58	FEE SCHEDULE LAB	8,362,743.73	301,225.64
EKG/ECG	285,831.00	21,546.00	MRI SERVICES	97,629.00	101,037.00
IV THERAPY	1,138,112.00	8,432.00	PROFESSIONAL FEES	0.00	122.00
OPERATING ROOM	4,124,390.59	1,003,061.45	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	192,634.00	0.00	REHAB THERAPY	0.00	2,321.00
RESPIRATORY SERVICES	176,667.00	64,898.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,094,982.00	2,134.00	AMBULANCE	0.00	0.00
GI SERVICES	43,822.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,151,691.61	22,697.39	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,329,900.00	2,822.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,272,711.17	837,300.75
RADIOLOGY THERAPEUTIC	197,223.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	12,288.00	5,604.12	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	16,653.00	8,744.66	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	20,367.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,347,425.00	15,408.37	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	364,363.50	1,195,375.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	315.00
OTHER IMAGING SERVICE	350,460.00	83,366.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	591,641.00	812.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	524,659.00	154,155.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	414,683.00	247,319.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	179,840.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,673,977.00	295,856.00			
			TOTAL ANCILLARY	42,494,000.76	5,492,875.03
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	42,494,000.76	5,492,875.03

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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MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016117066519	04/20/16 - 04/20/16	05/02/16	0.00	315.00	0.00	0.00	0.00
TOTAL				0.00	315.00	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 CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	778,988.42	ADJUSTMENTS	0.00
COVERED CHARGES	503,007.35	CONTRACTUAL ALLOW	204,474.26
NON-COVERD CHARGES	275,981.07	TOTAL MEDICAID LIAB	298,533.09
		LESS: COB	298,327.26
		LESS: COPAYMENT	205.83
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 273

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

MEDICAL CENTER, NAVICENT HEALTH (THE) PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
 777 HEMLOCK ST 000001207A SERVICE DATES 10/01/15 THROUGH 09/30/16
 MACON,GA 31201-2102 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,751.79	3,053.83	OTHER LAB	7,512.00	0.00
MED/SURG SUPPLY	16,626.00	18,257.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	33,299.00	2,907.00	OTHER THERAPEUTIC SVC	0.00	260.00
CT SCAN	31,966.00	32,463.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	63,359.00	1,467.00
EKG/ECG	3,420.00	513.00	MRI SERVICES	0.00	0.00
IV THERAPY	11,393.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	55,596.83	56,269.17	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	16,017.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,051.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	24,848.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	68,262.50	1,566.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	31,335.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	33,170.23	61,559.57
RADIOLOGY THERAPEUTIC	2,334.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,674.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	34,903.00	25.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,024.00	55,718.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,662.00	2,348.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,022.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	13,694.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	6,056.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,031.00	39,574.00			
			TOTAL ANCILLARY	503,007.35	275,981.07
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	503,007.35	275,981.07

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, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,149,320.54	ADJUSTMENTS	1,309.56
COVERED CHARGES	1,057,279.50	CONTRACTUAL ALLOW	1,014,861.82
NON-COVERD CHARGES	92,041.04	TOTAL MEDICAID LIAB	42,417.68
		LESS: COB	1,749.30
		LESS: COPAYMENT	1,579.16
		REIMBURSEMENT	39,089.22
		TOTAL NUMBER OF CLAIMS	727

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL CENTER, NAVICENT HEALTH (THE) PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
 777 HEMLOCK ST 000001207A SERVICE DATES 10/01/15 THROUGH 09/30/16
 MACON,GA 31201-2102 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	53,260.77	630.00	OTHER LAB	4,416.00	0.00
MED/SURG SUPPLY	2,096.00	274.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	89,916.00	16,010.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	97,135.00	54,635.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	160,425.00	9,210.00
EKG/ECG	7,695.00	171.00	MRI SERVICES	9,574.00	0.00
IV THERAPY	32,792.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,729.00	3,861.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,456.00	334.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,916.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	549,295.00	1,277.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,948.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,726.73	2,360.04
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	3,127.00	25.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,054.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,802.00	3,254.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,856.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,060.00	0.00			
			TOTAL ANCILLARY	1,057,279.50	92,041.04
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,057,279.50	92,041.04

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, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,928.06	ADJUSTMENTS	0.00
COVERED CHARGES	24,057.84	CONTRACTUAL ALLOW	17,505.86
NON-COVERD CHARGES	1,870.22	TOTAL MEDICAID LIAB	6,551.98
		LESS: COB	6,530.98
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	11

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL CENTER, NAVICENT HEALTH (THE)
 777 HEMLOCK ST
 MACON,GA 31201-2102

PROVIDER NUMBER
 000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	820.96	151.26	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,014.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,020.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,974.00	382.00
EKG/ECG	0.00	0.00	MRI SERVICES	3,797.00	0.00
IV THERAPY	86.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	126.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,927.00	1,279.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	52.88	57.96
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,240.00	0.00			
			TOTAL ANCILLARY	24,057.84	1,870.22
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	24,057.84	1,870.22

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

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,774,085.33	ADJUSTMENTS	162,857.70
COVERED CHARGES	6,732,912.19	CONTRACTUAL ALLOW	5,653,907.86
NON-COVERD CHARGES	1,041,173.14	TOTAL MEDICAID LIAB	1,079,004.33
		LESS: COB	0.00
		LESS: COPAYMENT	459.00
		REIMBURSEMENT	1,078,545.33

TOTAL NUMBER OF CLAIMS 179

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

MEDICAL CENTER, NAVICENT HEALTH (THE)
 777 HEMLOCK ST
 MACON,GA 31201-2102

PROVIDER NUMBER
 000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	181,370.28	15,406.15	OTHER LAB	22,532.00	0.00
MED/SURG SUPPLY	328,660.75	112,959.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	83,640.00	89,153.00	OTHER THERAPEUTIC SVC	0.00	3,703.00
CT SCAN	105,161.00	34,849.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,525.00	3,267.16	FEE SCHEDULE LAB	159,821.00	4,262.00
EKG/ECG	17,442.00	3,249.00	MRI SERVICES	45,828.00	7,456.00
IV THERAPY	95,885.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	567,532.03	95,442.33	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	16,692.00	7,773.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	72,702.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	128,241.00	6,413.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	57,345.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,780,451.45	94,450.43
RADIOLOGY THERAPEUTIC	48,223.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	397.00	892.06	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	955.01	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	5,618.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,621.00	96.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	858,712.68	427,461.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,692.00	1,152.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,685.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	20,961.00	4,779.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	292,968.00	72,580.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	761.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	828,063.00	49,257.00			
			TOTAL ANCILLARY	6,732,912.19	1,041,173.14
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,732,912.19	1,041,173.14

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 CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/15	THROUGH	09/30/16
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

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	352,917.46	ADJUSTMENTS	37,656.09
COVERED CHARGES	344,649.46	CONTRACTUAL ALLOW	116,058.44
NON-COVERD CHARGES	8,268.00	TOTAL MEDICAID LIAB	228,591.02
		LESS: COB	5,639.38
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	222,951.64

TOTAL NUMBER OF ADMISSIONS 32

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	118		0	37,760.00		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	118		0	37,760.00		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	118		0	37,760.00		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: 08/24/2017
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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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	87,772.41	0.00	OTHER LAB	382.00	0.00
MED/SURG SUPPLY	22,013.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	57,739.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,040.00	0.00	OTHER THERAPEUTIC SVC	0.00	88.00
CT SCAN	8,271.00	3,902.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	982.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,078.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,904.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,365.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	67,888.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	324.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	24,829.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	608.75	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	269.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,860.00	4,278.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	612.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,846.00	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	3,106.00	0.00			
			TOTAL ANCILLARY	306,889.46	8,268.00
			TOTAL ACCOMODATIONS	37,760.00	0.00
			TOTAL CHARGES	344,649.46	8,268.00

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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Run Time: 04:20:52
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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	09/01/15	THROUGH	08/31/16
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: 08/24/2017
Run Time: 04:20:52
Page: 4

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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,420,418.53	ADJUSTMENTS	116,472.55
COVERED CHARGES	1,366,117.04	CONTRACTUAL ALLOW	922,774.39
NON-COVERD CHARGES	54,301.49	TOTAL MEDICAID LIAB	443,342.65
		LESS: COB	434.92
		LESS: COPAYMENT	1,413.00
		REIMBURSEMENT	441,494.73
		ALL OTHER	394,464.73
		FEE SCHEDULE-LAB	43,116.33
		INJECTABLE DRUGS	3,913.67

TOTAL NUMBER OF CLAIMS 1,438

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	49,266.93	11.45	OTHER LAB	8,501.00	0.00
MED/SURG SUPPLY	48,307.90	661.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	80,196.00	0.00	OTHER THERAPEUTIC SVC	0.00	88.00
CT SCAN	119,460.00	9,947.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,979.00	9,444.04	FEE SCHEDULE LAB	248,303.00	10,158.00
EKG/ECG	13,561.00	0.00	MRI SERVICES	17,491.70	884.00
IV THERAPY	70,016.28	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	117,311.72	12,909.34	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	47,163.00	287.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	30,294.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	347,784.51	222.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,910.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	21,157.00	1,227.15
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,072.00	3,503.06	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	272.00	1,052.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,260.00	90.45	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,200.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	29,170.00	1,253.00			
BLOOD	95.00	0.00			
BLOOD STORAGE & PRO.	12,540.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,826.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,128.00	2,564.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	41,400.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	38,451.00	0.00			
			TOTAL ANCILLARY	1,366,117.04	54,301.49
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,366,117.04	54,301.49

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

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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,465.48	ADJUSTMENTS	0.00
COVERED CHARGES	6,539.63	CONTRACTUAL ALLOW	2,987.46
NON-COVERD CHARGES	1,925.85	TOTAL MEDICAID LIAB	3,552.17
		LESS: COB	3,531.17
		LESS: COPAYMENT	21.00
		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

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	297.38	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	207.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	115.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,206.00	405.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	1,479.00
IV THERAPY	212.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,137.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16.25	41.85
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,349.00	0.00			
			TOTAL ANCILLARY	6,539.63	1,925.85
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,539.63	1,925.85

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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	122,173.87	ADJUSTMENTS	955.92
COVERED CHARGES	117,295.22	CONTRACTUAL ALLOW	106,442.86
NON-COVERD CHARGES	4,878.65	TOTAL MEDICAID LIAB	10,852.36
		LESS: COB	0.00
		LESS: COPAYMENT	409.45
		REIMBURSEMENT	10,442.91
		TOTAL NUMBER OF CLAIMS	194

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,433.42	15.35	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,159.70	137.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,391.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,664.00	2,473.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,972.00	1,726.00
EKG/ECG	729.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,550.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,856.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	66,718.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,235.10	436.85
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	90.45	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	587.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	117,295.22	4,878.65
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	117,295.22	4,878.65

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: 08/24/2017
Run Time: 04:21:00
Page: 10

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	09/01/15	THROUGH	08/31/16
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: 08/24/2017
Run Time: 04:21:00
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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	09/01/15	THROUGH	08/31/16
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: 08/24/2017
Run Time: 04:21:00
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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	09/01/15	THROUGH	08/31/16
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: 08/24/2017
 Run Time: 03:47:01
 Page: 1

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,546,602.34	ADJUSTMENTS	674,870.76
COVERED CHARGES	16,292,970.04	CONTRACTUAL ALLOW	10,597,440.14
NON-COVERD CHARGES	253,632.30	TOTAL MEDICAID LIAB	5,695,529.90
		LESS: COB	30,520.31
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,665,009.59

TOTAL NUMBER OF ADMISSIONS 600

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,957		0	1,491,265.00		188,810.00
ROUTINE NURSERY	97		0	50,055.00		4,820.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,054		0	1,541,320.00		193,630.00
SPECIAL CARE SERVICES						
CCU	830		0	909,520.00		0.00
ICU	160		0	264,000.00		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	990		0	1,173,520.00		0.00
TOTAL ACCOMODATIONS	3,044		0	2,714,840.00		193,630.00

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,704,397.63	7,933.00	OTHER LAB	96,083.00	0.00
MED/SURG SUPPLY	1,212,265.16	8,915.17	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,576,766.00	1,508.00	EDUCATION & TRAINING	15,684.00	60.00
RADIOLOGY-DIAGNOSTIC	239,700.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	891,285.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	143,768.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	136,300.20	0.00	MRI SERVICES	139,702.00	0.00
IV THERAPY	263,563.00	988.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,148,170.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	55,591.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,807,653.00	8,308.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	41,525.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	108,562.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	549,978.00	955.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	48,984.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	755.13
LABORATORY PATHOLOGIC	24,089.00	0.00	INJECTABLE DRUGS	11,148.80	0.00
RADIOLOGY THERAPEUTIC	15,430.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	11,148.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	8,054.03	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	175,862.00	6,354.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	802.00	11,395.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	500,598.70	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	123,576.00	4,498.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	200,437.00	1,600.00			
ONCOLOGY	280.00	0.00			
NUCLEAR MEDICINE	113,559.00	0.00			
AUDIOLOGY	7,808.00	0.00			
CARDIOLOGY	956,348.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	11,487.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	237,525.00	6,733.00			
			TOTAL ANCILLARY	13,578,130.04	60,002.30
			TOTAL ACCOMODATIONS	2,714,840.00	193,630.00
			TOTAL CHARGES	16,292,970.04	253,632.30

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,747.64	ADJUSTMENTS	0.00
COVERED CHARGES	21,702.64	CONTRACTUAL ALLOW	7,887.25
NON-COVERD CHARGES	45.00	TOTAL MEDICAID LIAB	13,815.39
		LESS: COB	13,815.39
		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	1,710.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2		0	1,710.00		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	1,710.00		0.00

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,871.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,029.14	45.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	241.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	13,703.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	448.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,062.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	736.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	628.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	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	274.00	0.00			
			TOTAL ANCILLARY	19,992.64	45.00
			TOTAL ACCOMODATIONS	1,710.00	0.00
			TOTAL CHARGES	21,702.64	45.00

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: 08/24/2017
Run Time: 03:47:11
Page: 5

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,540,194.66	ADJUSTMENTS	394,646.34
COVERED CHARGES	18,052,529.82	CONTRACTUAL ALLOW	13,851,761.76
NON-COVERD CHARGES	1,487,664.84	TOTAL MEDICAID LIAB	4,200,768.06
		LESS: COB	3,246.11
		LESS: COPAYMENT	9,814.67
		REIMBURSEMENT	4,187,707.28
		ALL OTHER	2,860,404.92
		FEE SCHEDULE-LAB	350,905.62
		INJECTABLE DRUGS	976,396.74

TOTAL NUMBER OF CLAIMS 8,448

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	817,734.97	186.00	OTHER LAB	488,353.00	875.00
MED/SURG SUPPLY	636,830.04	4,868.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	1,072.00
RADIOLOGY-DIAGNOSTIC	546,769.00	10,970.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,202,559.00	296,211.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	45,040.00	7,044.02	FEE SCHEDULE LAB	2,239,888.00	136,680.00
EKG/ECG	228,793.00	6,480.00	MRI SERVICES	542,599.00	61,201.00
IV THERAPY	970,482.00	21,996.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	991,085.92	94,778.13	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	33,525.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	165,286.00	26,198.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	88,045.00	2,052.00	AMBULANCE	0.00	0.00
GI SERVICES	561,639.82	27,622.18	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,840,878.00	1,680.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	191,223.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,086,054.42	436,144.85
RADIOLOGY THERAPEUTIC	27,642.00	274.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,730.00	2,558.03	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,752.00	570.03	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	121,861.00	5,001.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	131,725.65	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	593,121.00	55,100.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	60,693.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	397,906.00	62,581.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	746,469.00	213,691.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,914.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	282,931.00	11,831.00			
			TOTAL ANCILLARY	18,052,529.82	1,487,664.84
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,052,529.82	1,487,664.84

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

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	220,154.69	ADJUSTMENTS	0.00
COVERED CHARGES	186,655.14	CONTRACTUAL ALLOW	79,714.91
NON-COVERD CHARGES	33,499.55	TOTAL MEDICAID LIAB	106,940.23
		LESS: COB	106,871.23
		LESS: COPAYMENT	69.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 96

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,809.07	0.00	OTHER LAB	7,102.00	0.00
MED/SURG SUPPLY	6,831.67	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	70.00
RADIOLOGY-DIAGNOSTIC	6,193.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	25,920.00	10,803.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	30,614.00	5,585.00
EKG/ECG	2,333.00	0.00	MRI SERVICES	3,333.00	2,844.00
IV THERAPY	12,540.00	430.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,815.00	5,561.55	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	667.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,887.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	4,212.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	26,573.00	189.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,784.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	23,222.40	929.00
RADIOLOGY THERAPEUTIC	404.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	618.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,413.00	1,989.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,859.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,177.00	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	2,560.00	0.00			
			TOTAL ANCILLARY	186,655.14	33,499.55
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	186,655.14	33,499.55

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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	980,411.49	ADJUSTMENTS	572.27
COVERED CHARGES	911,227.49	CONTRACTUAL ALLOW	871,779.85
NON-COVERD CHARGES	69,184.00	TOTAL MEDICAID LIAB	39,447.64
		LESS: COB	26.81
		LESS: COPAYMENT	1,487.07
		REIMBURSEMENT	37,933.76
		TOTAL NUMBER OF CLAIMS	706

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,758.79	47.00	OTHER LAB	11,967.00	0.00
MED/SURG SUPPLY	25,286.51	1,132.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	64,803.00	3,038.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	192,374.00	54,302.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	128,268.00	4,313.00
EKG/ECG	12,704.00	216.00	MRI SERVICES	0.00	0.00
IV THERAPY	57,239.00	418.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,261.00	92.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	362,701.00	102.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,817.19	1,264.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	73.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	17,013.00	1,787.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,035.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	2,400.00			
			TOTAL ANCILLARY	911,227.49	69,184.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	911,227.49	69,184.00

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

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

Run Date: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,903.83	ADJUSTMENTS	0.00
COVERED CHARGES	18,902.83	CONTRACTUAL ALLOW	8,326.60
NON-COVERD CHARGES	2,001.00	TOTAL MEDICAID LIAB	10,576.23
		LESS: COB	10,557.96
		LESS: COPAYMENT	18.27
		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

Run Date: 08/24/2017
 Run Time: 03:48:09
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	487.00	0.00	OTHER LAB	707.00	0.00
MED/SURG SUPPLY	635.83	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,645.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,152.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,644.00	736.00
EKG/ECG	432.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,147.00	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	92.00	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	9,879.00	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	188.00	24.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,046.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	18,902.83	2,001.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,902.83	2,001.00

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

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

Run Date: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,173,663.07	ADJUSTMENTS	79,703.10
COVERED CHARGES	2,142,503.07	CONTRACTUAL ALLOW	1,713,513.28
NON-COVERD CHARGES	31,160.00	TOTAL MEDICAID LIAB	428,989.79
		LESS: COB	7,167.47
		LESS: COPAYMENT	279.00
		REIMBURSEMENT	421,543.32

TOTAL NUMBER OF CLAIMS 75

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	01/01/16	THROUGH	12/31/16
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	47,626.06	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	65,693.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	114.00	38.00
RADIOLOGY-DIAGNOSTIC	9,540.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,032.00	1,516.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	251.00	0.00	FEE SCHEDULE LAB	26,276.00	386.00
EKG/ECG	5,164.00	1,080.00	MRI SERVICES	3,659.00	0.00
IV THERAPY	83,674.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	77,153.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,194.00	420.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,300.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,974.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,554.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,470,693.26	10,632.00
RADIOLOGY THERAPEUTIC	4,492.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	124,556.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,269.00	660.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,020.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	167,152.00	16,428.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	35,116.00	0.00			
			TOTAL ANCILLARY	2,142,503.07	31,160.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,142,503.07	31,160.00

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

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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	01/01/16	THROUGH	12/31/16
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: 08/24/2017
 Run Time: 02:36:50
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	382,837.17	ADJUSTMENTS	45,827.90
COVERED CHARGES	338,663.57	CONTRACTUAL ALLOW	196,803.54
NON-COVERD CHARGES	44,173.60	TOTAL MEDICAID LIAB	141,860.03
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	141,860.03

TOTAL NUMBER OF ADMISSIONS 25

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	114		0	84,360.00		40,107.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	114		0	84,360.00		40,107.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	84,360.00		40,107.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39,692.48	0.00	OTHER LAB	761.84	0.00
MED/SURG SUPPLY	6,269.51	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	70,155.35	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,583.13	0.00	OTHER THERAPEUTIC SVC	0.00	184.82
CT SCAN	15,059.57	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,173.83	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	5,653.83	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,591.74	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	409.82	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	27,595.86	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	59,862.07	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,673.73	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	376.09	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	146.32
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	101.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	794.64	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,400.87	3,735.46			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,061.34	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,086.87	0.00			
			TOTAL ANCILLARY	254,303.57	4,066.60
			TOTAL ACCOMODATIONS	84,360.00	40,107.00
			TOTAL CHARGES	338,663.57	44,173.60

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

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 07/01/15 THROUGH 06/30/16
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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,862,148.60	ADJUSTMENTS	48,456.44
COVERED CHARGES	1,654,246.43	CONTRACTUAL ALLOW	1,352,759.83
NON-COVERD CHARGES	207,902.17	TOTAL MEDICAID LIAB	301,486.60
		LESS: COB	175.02
		LESS: COPAYMENT	972.00
		REIMBURSEMENT	300,339.58
		ALL OTHER	258,580.02
		FEE SCHEDULE-LAB	41,727.16
		INJECTABLE DRUGS	32.40
		TOTAL NUMBER OF CLAIMS	1,429

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	62,044.98	11,487.70	OTHER LAB	39,594.49	450.00
MED/SURG SUPPLY	31,746.74	1,018.72	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	129,164.21	459.91	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	252,955.80	44,078.01	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,736.56	15,002.76	FEE SCHEDULE LAB	483,632.88	55,963.17
EKG/ECG	19,835.18	1,845.15	MRI SERVICES	0.00	0.00
IV THERAPY	53,255.54	3,945.98	PROFESSIONAL FEES	0.00	8,247.89
OPERATING ROOM	7,130.01	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,583.95	150.88	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,731.33	0.00	AMBULANCE	0.00	0.00
GI SERVICES	43,672.51	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	405,872.12	3,800.43	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	548.08	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,775.65	42,535.64
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	402.16	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	629.75	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	61,338.59	13,319.77			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,211.38	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,022.89	836.95			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	16,612.07	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	21,781.47	3,727.30			
			TOTAL ANCILLARY	1,654,246.43	207,902.17
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,654,246.43	207,902.17

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	40,267.95	ADJUSTMENTS	0.00
COVERED CHARGES	30,647.23	CONTRACTUAL ALLOW	10,443.54
NON-COVERD CHARGES	9,620.72	TOTAL MEDICAID LIAB	20,203.69
		LESS: COB	20,188.69
		LESS: COPAYMENT	15.00
		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

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,664.80	0.00	OTHER LAB	3,700.00	0.00
MED/SURG SUPPLY	1,020.67	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,277.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	5,335.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,763.52	248.08
EKG/ECG	467.09	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	876.19	0.00	PROFESSIONAL FEES	0.00	3,939.84
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	54.02	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,970.62	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	108.75	97.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,404.86	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	339.46	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	30,647.23	9,620.72
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	30,647.23	9,620.72

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

Run Date: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	143,763.19	ADJUSTMENTS	264.70
COVERED CHARGES	131,260.70	CONTRACTUAL ALLOW	116,887.01
NON-COVERD CHARGES	12,502.49	TOTAL MEDICAID LIAB	14,373.69
		LESS: COB	0.00
		LESS: COPAYMENT	522.00
		REIMBURSEMENT	13,851.69
		TOTAL NUMBER OF CLAIMS	258

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,633.14	1,084.54	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,396.38	130.08	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,747.35	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,589.54	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	24,832.87	883.86
EKG/ECG	915.45	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,265.86	0.00	PROFESSIONAL FEES	0.00	677.31
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	54.02	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	85,112.19	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	106.45	7,740.12
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	939.46	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	667.99	1,986.58			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	131,260.70	12,502.49
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	131,260.70	12,502.49

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

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,276.14	ADJUSTMENTS	0.00
COVERED CHARGES	2,431.61	CONTRACTUAL ALLOW	1,327.33
NON-COVERD CHARGES	844.53	TOTAL MEDICAID LIAB	1,104.28
		LESS: COB	1,101.28
		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: 08/24/2017
 Run Time: 02:37:07
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	296.20	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	28.09	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	437.98	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	538.76	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,095.48	688.28	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	35.10	156.25
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	2,431.61	844.53
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,431.61	844.53

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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
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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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
 Run Time: 03:46:06
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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 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,458,886.41	ADJUSTMENTS	263,930.03
COVERED CHARGES	2,422,537.41	CONTRACTUAL ALLOW	1,205,196.44
NON-COVERD CHARGES	36,349.00	TOTAL MEDICAID LIAB	1,217,340.97
		LESS: COB	1,234.28
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,216,106.69

TOTAL NUMBER OF ADMISSIONS 223

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	528		2	329,010.00		17,232.00
ROUTINE NURSERY	90		0	49,396.00		948.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	618		2	378,406.00		18,180.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	71		0	91,010.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	71		0	91,010.00		0.00
TOTAL ACCOMODATIONS	689		2	469,416.00		18,180.00

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 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	350,799.70	0.00	OTHER LAB	9,849.00	0.00
MED/SURG SUPPLY	181,407.45	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	461,861.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	45,343.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	189,996.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,702.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	31,198.00	0.00	MRI SERVICES	45,731.00	0.00
IV THERAPY	449.00	0.00	PROFESSIONAL FEES	0.00	1,089.00
OPERATING ROOM	110,696.00	4,646.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	176,753.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	70,879.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,730.70	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	173,040.00	0.00	SPECIAL SERVICES	0.00	2,567.00
RECOVERY ROOM	18,106.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,265.00	0.00	INJECTABLE DRUGS	731.50	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	1,339.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	921.06	379.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,954.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,703.00	8,622.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,922.00	0.00			
AUDIOLOGY	4,199.00	0.00			
CARDIOLOGY	27,910.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,636.00	866.00			
			TOTAL ANCILLARY	1,953,121.41	18,169.00
			TOTAL ACCOMODATIONS	469,416.00	18,180.00
			TOTAL CHARGES	2,422,537.41	36,349.00

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: 08/24/2017
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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 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,357.84	ADJUSTMENTS	0.00
COVERED CHARGES	16,357.84	CONTRACTUAL ALLOW	5,205.95
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	11,151.89
		LESS: COB	11,151.89
		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	1,292.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2		0	1,292.00		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	1,292.00		0.00

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 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	902.84	0.00	OTHER LAB	170.00	0.00
MED/SURG SUPPLY	520.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,369.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	501.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	9,969.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	298.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	336.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	15,065.84	0.00
			TOTAL ACCOMODATIONS	1,292.00	0.00
			TOTAL CHARGES	16,357.84	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: 08/24/2017
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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 04/01/15 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,426,905.44	ADJUSTMENTS	59,890.91
COVERED CHARGES	3,101,322.62	CONTRACTUAL ALLOW	2,471,534.12
NON-COVERD CHARGES	325,582.82	TOTAL MEDICAID LIAB	629,788.50
		LESS: COB	1,921.83
		LESS: COPAYMENT	2,745.12
		REIMBURSEMENT	625,121.55
		ALL OTHER	512,577.35
		FEE SCHEDULE-LAB	105,344.00
		INJECTABLE DRUGS	7,200.20

TOTAL NUMBER OF CLAIMS 3,365

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: 08/24/2017
 Run Time: 03:46:12
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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 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	70,609.32	7,653.48	OTHER LAB	15,338.00	0.00
MED/SURG SUPPLY	116,603.00	8,931.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	286.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	212,046.00	3,200.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	350,392.00	57,193.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	25,655.00	5,385.00	FEE SCHEDULE LAB	937,823.20	59,814.95
EKG/ECG	41,720.00	3,919.00	MRI SERVICES	101,559.00	23,583.00
IV THERAPY	8,920.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	206,447.00	83,044.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,124.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,491.00	9,482.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,339.20	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	627,956.00	11,088.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	45,541.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	47,179.90	33,339.64
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	19,824.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	3,952.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	25.75
OTHER IMAGING SERVICE	83,118.00	6,875.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,337.00	1,809.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,030.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	20,439.00	2,723.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	48,922.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	92,909.00	3,279.00			
			TOTAL ANCILLARY	3,101,322.62	325,582.82
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,101,322.62	325,582.82

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: 08/24/2017
Run Time: 03:46:12
Page: 7

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 04/01/15 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
363	5915166000755	05/28/15 - 05/29/15	06/22/15	0.00	25.75	0.00	0.00	0.00
TOTAL				0.00	25.75	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: 08/24/2017
Run Time: 03:46:49
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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 04/01/15 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,907.70	ADJUSTMENTS	0.00
COVERED CHARGES	26,324.86	CONTRACTUAL ALLOW	13,722.12
NON-COVERD CHARGES	1,582.84	TOTAL MEDICAID LIAB	12,602.74
		LESS: COB	12,575.74
		LESS: COPAYMENT	27.00
		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

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 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	247.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,396.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,414.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,690.00	1,471.00
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	5,632.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	145.70	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,330.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,556.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	173.66	111.84
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	515.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	26,324.86	1,582.84
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	26,324.86	1,582.84

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: 08/24/2017
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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 04/01/15 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	106,534.60	ADJUSTMENTS	161.82
COVERED CHARGES	102,051.40	CONTRACTUAL ALLOW	87,339.18
NON-COVERD CHARGES	4,483.20	TOTAL MEDICAID LIAB	14,712.22
		LESS: COB	0.00
		LESS: COPAYMENT	462.00
		REIMBURSEMENT	14,250.22
		TOTAL NUMBER OF CLAIMS	263

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

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

Run Date: 08/24/2017
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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 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,359.35	55.30	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	727.00	74.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,639.00	135.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,982.00	3,396.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	195.00	0.00	FEE SCHEDULE LAB	11,240.00	445.00
EKG/ECG	450.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	54.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	76,877.00	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	1,081.05	377.90
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	447.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	102,051.40	4,483.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	102,051.40	4,483.20

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

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	04/01/15	THROUGH	03/31/16
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: 08/24/2017
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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 04/01/15 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	64,860.68	ADJUSTMENTS	0.00
COVERED CHARGES	30,568.68	CONTRACTUAL ALLOW	26,114.82
NON-COVERD CHARGES	34,292.00	TOTAL MEDICAID LIAB	4,453.86
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	4,450.86

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: 08/24/2017
 Run Time: 03:46:53
 Page: 14

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 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,200.68	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,368.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	8,360.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	5,432.00	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	30,568.68	13,792.00
			TOTAL ACCOMODATIONS	0.00	20,500.00
			TOTAL CHARGES	30,568.68	34,292.00

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: 08/24/2017
Run Time: 03:46:54
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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	04/01/15	THROUGH	03/31/16
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: 08/24/2017
 Run Time: 03:43:23
 Page: 1

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	128,695,917.96	ADJUSTMENTS	6,064,296.44
COVERED CHARGES	124,748,683.92	CONTRACTUAL ALLOW	82,498,411.30
NON-COVERD CHARGES	3,947,234.04	TOTAL MEDICAID LIAB	42,250,272.62
		LESS: COB	354,935.36
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	41,895,337.26

TOTAL NUMBER OF ADMISSIONS 3,373

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	14,927		6	13,195,468.00		2,637,557.00
ROUTINE NURSERY	1,589		0	3,033,671.00		10,968.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		2.00
TOTAL ROUTINE	16,516		6	16,229,139.00		2,648,527.00
SPECIAL CARE SERVICES						
CCU	134		0	404,546.00		0.00
ICU	4,203		3	8,408,765.00		4,416.00
NICU	1,443		0	4,735,926.00		0.00
PED ICU	523		0	2,063,758.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	437		0	1,319,303.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	6,740		3	16,932,298.00		4,416.00
TOTAL ACCOMODATIONS	23,256		9	33,161,437.00		2,652,943.00

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

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

Run Date: 08/24/2017
 Run Time: 03:43:23
 Page: 2

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,623,740.14	0.00	OTHER LAB	710,235.54	0.00
MED/SURG SUPPLY	6,603,371.26	161,691.15	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,928,418.91	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,062,432.81	0.00	OTHER THERAPEUTIC SVC	6,423.00	94,300.00
CT SCAN	3,205,583.70	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	934,277.81	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	441,030.00	0.00	MRI SERVICES	1,244,541.60	0.00
IV THERAPY	952,823.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,191,787.37	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	851,202.00	0.00	REHAB THERAPY	12,636.00	0.00
RESPIRATORY SERVICES	5,789,330.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,316,494.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	283,509.00	3,643.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,736,108.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,773,270.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	270,034.61	0.00	INJECTABLE DRUGS	5,755,444.08	12,679.14
RADIOLOGY THERAPEUTIC	722,980.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	608,257.54	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	295,674.20	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	805,106.00	885.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	34,338.00	2,318.00	TRAUMA RESPONSE	0.00	39,726.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,193,813.78	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	761,499.56	49,125.60			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,162,927.00	815,954.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	486,444.06	113,969.15			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,486,301.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	175,674.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	161,538.95	0.00			
			TOTAL ANCILLARY	91,587,246.92	1,294,291.04
			TOTAL ACCOMODATIONS	33,161,437.00	2,652,943.00
			TOTAL CHARGES	124,748,683.92	3,947,234.04

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

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

Run Date: 08/24/2017
 Run Time: 03:44:08
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,882,573.01	ADJUSTMENTS	0.00
COVERED CHARGES	2,771,947.31	CONTRACTUAL ALLOW	1,299,227.83
NON-COVERD CHARGES	110,625.70	TOTAL MEDICAID LIAB	1,472,719.48
		LESS: COB	1,472,719.48
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 54

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	171		0	151,164.00		77,614.00
ROUTINE NURSERY	149		0	398,603.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	320		0	549,767.00		77,614.00
SPECIAL CARE SERVICES						
CCU	2		0	6,038.00		0.00
ICU	51		0	120,124.00		0.00
NICU	144		0	472,608.00		0.00
PED ICU	14		0	55,244.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	211		0	654,014.00		0.00
TOTAL ACCOMODATIONS	531		0	1,203,781.00		77,614.00

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	171,627.83	0.00	OTHER LAB	18,246.00	0.00
MED/SURG SUPPLY	104,925.84	2,282.70	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	198,300.57	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	83,369.00	0.00	OTHER THERAPEUTIC SVC	0.00	202.00
CT SCAN	25,982.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,557.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,576.00	0.00	MRI SERVICES	17,922.30	0.00
IV THERAPY	9,150.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	250,896.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	11,406.00	0.00	REHAB THERAPY	156.00	0.00
RESPIRATORY SERVICES	210,293.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	76,495.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	44,331.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	31,921.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	4,846.01	0.00	INJECTABLE DRUGS	67,373.46	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,186.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,429.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	12,640.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	472.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	129,579.20	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	16,508.60	6,965.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	28,237.00	22,230.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	1,332.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,106.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	24,634.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,568,166.31	33,011.70
			TOTAL ACCOMODATIONS	1,203,781.00	77,614.00
			TOTAL CHARGES	2,771,947.31	110,625.70

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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	36,865,489.91	ADJUSTMENTS	523,436.69
COVERED CHARGES	29,848,870.74	CONTRACTUAL ALLOW	25,205,016.33
NON-COVERD CHARGES	7,016,619.17	TOTAL MEDICAID LIAB	4,643,854.41
		LESS: COB	71,618.17
		LESS: COPAYMENT	13,168.57
		REIMBURSEMENT	4,559,067.67
		ALL OTHER	3,765,746.88
		FEE SCHEDULE-LAB	411,358.44
		INJECTABLE DRUGS	381,962.35
		TOTAL NUMBER OF CLAIMS	12,333

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	659,940.49	74.59	OTHER LAB	733,635.90	4,052.00
MED/SURG SUPPLY	1,264,604.71	17,130.03	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	2,221.00
RADIOLOGY-DIAGNOSTIC	1,453,435.99	23,544.00	OTHER THERAPEUTIC SVC	9,254.00	68,061.00
CT SCAN	1,826,974.16	363,468.24	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	153,245.00	55,776.58	FEE SCHEDULE LAB	2,830,079.07	190,800.06
EKG/ECG	245,172.00	20,240.00	MRI SERVICES	842,967.80	196,882.52
IV THERAPY	1,068,820.00	20,084.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,229,558.30	722,463.70	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	89,626.00	250.00	REHAB THERAPY	0.00	780.00
RESPIRATORY SERVICES	159,877.00	20,562.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,564,180.00	10,908.00	AMBULANCE	0.00	0.00
GI SERVICES	230,450.00	89,084.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,539,198.00	21,910.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	964,769.00	1,199.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,520,575.40	1,324,625.94
RADIOLOGY THERAPEUTIC	1,327,172.00	2,392,809.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	64,615.00	50,170.36	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	44,981.00	15,479.26	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	22,932.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	182,395.00	4,305.00	TRAUMA RESPONSE	0.00	4,414.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	424,126.35	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	898,230.72	238,271.72			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	286,402.00	125,483.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	481,908.62	840,491.40			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	245,262.00	167,432.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	40,561.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	466,854.23	714.77			
			TOTAL ANCILLARY	29,848,870.74	7,016,619.17
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	29,848,870.74	7,016,619.17

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

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	614,294.22	ADJUSTMENTS	0.00
COVERED CHARGES	448,218.65	CONTRACTUAL ALLOW	270,164.19
NON-COVERD CHARGES	166,075.57	TOTAL MEDICAID LIAB	178,054.46
		LESS: COB	177,907.46
		LESS: COPAYMENT	147.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 196

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,504.63	0.00	OTHER LAB	5,748.80	0.00
MED/SURG SUPPLY	10,917.33	250.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,638.45	0.00	OTHER THERAPEUTIC SVC	0.00	3,559.00
CT SCAN	26,079.34	28,119.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,644.00	0.00	FEE SCHEDULE LAB	40,927.36	4,334.80
EKG/ECG	2,208.00	0.00	MRI SERVICES	13,845.42	12,665.88
IV THERAPY	18,291.00	283.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	38,702.64	13,390.26	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,838.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	813.00	224.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	27,239.00	425.00	AMBULANCE	0.00	0.00
GI SERVICES	3,714.00	4,477.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	80,709.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,536.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	37,316.11	45,705.85
RADIOLOGY THERAPEUTIC	27,196.00	39,082.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,513.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	896.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,255.00	135.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,131.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,789.36	2,426.40			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	16,421.00	8,405.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,993.08	135.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,194.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,566.88	49.13			
			TOTAL ANCILLARY	448,218.65	166,075.57
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	448,218.65	166,075.57

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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	768,761.48	ADJUSTMENTS	326.64
COVERED CHARGES	724,921.04	CONTRACTUAL ALLOW	691,138.19
NON-COVERD CHARGES	43,840.44	TOTAL MEDICAID LIAB	33,782.85
		LESS: COB	882.00
		LESS: COPAYMENT	532.00
		REIMBURSEMENT	32,368.85
		TOTAL NUMBER OF CLAIMS	589

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

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

Run Date: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,619.44	0.00	OTHER LAB	4,551.00	0.00
MED/SURG SUPPLY	5,006.63	47.45	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	57,828.00	284.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	29,703.32	5,944.68	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	65,309.26	2,768.00
EKG/ECG	3,680.00	368.00	MRI SERVICES	6,553.60	0.00
IV THERAPY	26,510.00	762.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	20,606.96	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	29.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,956.00	850.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	454,319.00	295.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,639.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,755.70	13,734.31
RADIOLOGY THERAPEUTIC	1,414.00	11,528.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	346.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	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	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	451.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,683.60	6,884.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,861.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	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	4,310.28	0.00			
			TOTAL ANCILLARY	724,921.04	43,840.44
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	724,921.04	43,840.44

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

Run Date: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,335.63	ADJUSTMENTS	0.00
COVERED CHARGES	10,385.61	CONTRACTUAL ALLOW	903.53
NON-COVERD CHARGES	5,950.02	TOTAL MEDICAID LIAB	9,482.08
		LESS: COB	9,476.08
		LESS: COPAYMENT	6.00
		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

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42.73	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,287.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	5,950.02	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,085.33	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,360.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,311.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,058.55	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	241.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	10,385.61	5,950.02
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,385.61	5,950.02

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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,304,395.23	ADJUSTMENTS	103,901.35
COVERED CHARGES	4,771,903.18	CONTRACTUAL ALLOW	4,129,478.94
NON-COVERD CHARGES	532,492.05	TOTAL MEDICAID LIAB	642,424.24
		LESS: COB	0.00
		LESS: COPAYMENT	673.47
		REIMBURSEMENT	641,750.77

TOTAL NUMBER OF CLAIMS 105

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,748.60	0.00	OTHER LAB	2,692.30	0.00
MED/SURG SUPPLY	615,892.32	4,919.85	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	55,054.00	20,325.00	OTHER THERAPEUTIC SVC	0.00	5,576.00
CT SCAN	4,806.00	2,972.34	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	383.00	845.00	FEE SCHEDULE LAB	34,531.20	962.00
EKG/ECG	920.00	184.00	MRI SERVICES	1,717.80	1,717.80
IV THERAPY	27,022.00	1,519.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	601,375.04	60,370.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	780.00
RESPIRATORY SERVICES	896.00	112.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	138,786.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,532.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	62,093.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,171,512.49	94,853.06
RADIOLOGY THERAPEUTIC	165,249.00	30,923.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,146.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,432.00	118.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,709,696.35	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	18,547.32	4,488.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,198.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	39,554.92	7,073.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	65,701.00	290,608.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,562.84	0.00			
			TOTAL ANCILLARY	4,771,903.18	532,492.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,771,903.18	532,492.05

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: 08/24/2017
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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	01/01/16	THROUGH	12/31/16
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: 08/24/2017
 Run Time: 04:20:37
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	180,815.04	ADJUSTMENTS	0.00
COVERED CHARGES	179,298.04	CONTRACTUAL ALLOW	74,013.76
NON-COVERD CHARGES	1,517.00	TOTAL MEDICAID LIAB	105,284.28
		LESS: COB	841.30
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	104,442.98

TOTAL NUMBER OF ADMISSIONS 18

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	72		0	37,440.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	72		0	37,440.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	72		0	37,440.00		0.00

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,194.50	0.00	OTHER LAB	1,445.00	0.00
MED/SURG SUPPLY	10,508.84	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	24,567.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,843.00	0.00	OTHER THERAPEUTIC SVC	0.00	649.00
CT SCAN	10,717.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	541.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,668.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,017.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	18,934.45	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	7,850.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	15,038.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,020.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	288.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	449.00	0.00			
BLOOD	2,418.00	0.00			
BLOOD STORAGE & PRO.	684.00	868.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,654.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,021.00	0.00			
			TOTAL ANCILLARY	141,858.04	1,517.00
			TOTAL ACCOMODATIONS	37,440.00	0.00
			TOTAL CHARGES	179,298.04	1,517.00

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

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

Run Date: 08/24/2017
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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	01/01/16	THROUGH	12/31/16
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: 08/24/2017
Run Time: 04:20:37
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	657,528.01	ADJUSTMENTS	730.73
COVERED CHARGES	574,069.14	CONTRACTUAL ALLOW	382,473.74
NON-COVERD CHARGES	83,458.87	TOTAL MEDICAID LIAB	191,595.40
		LESS: COB	260.87
		LESS: COPAYMENT	431.76
		REIMBURSEMENT	190,902.77
		ALL OTHER	175,058.35
		FEE SCHEDULE-LAB	14,007.44
		INJECTABLE DRUGS	1,836.98

TOTAL NUMBER OF CLAIMS 586

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

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

Run Date: 08/24/2017
 Run Time: 04:20:37
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SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

MERIWETHER HEALTHCARE, LLC
 5995 SPRING ST
 WARM SPRINGS,GA 31830-2149

PROVIDER NUMBER
 000001284A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,516.00	11,089.00	OTHER LAB	3,358.00	0.00
MED/SURG SUPPLY	16,215.49	233.62	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	782.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,271.00	118.00	OTHER THERAPEUTIC SVC	0.00	19,686.25
CT SCAN	54,286.00	17,555.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	117,791.84	7,497.00
EKG/ECG	12,052.00	1,834.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,043.00	483.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,214.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,021.56	171.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	44,709.43	1,846.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	218,704.70	1,300.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,590.25	12,784.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	21,353.00	0.00			
BLOOD	1,612.00	1,612.00			
BLOOD STORAGE & PRO.	114.00	2,718.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,441.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,775.87	3,750.00			
			TOTAL ANCILLARY	574,069.14	83,458.87
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	574,069.14	83,458.87

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: 08/24/2017
Run Time: 04:20:41
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,984.40	ADJUSTMENTS	0.00
COVERED CHARGES	2,240.00	CONTRACTUAL ALLOW	-205.69
NON-COVERD CHARGES	1,744.40	TOTAL MEDICAID LIAB	2,445.69
		LESS: COB	2,442.69
		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

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	1,607.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	45.00	45.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	175.00	0.00	OTHER THERAPEUTIC SVC	0.00	75.00
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	1,903.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	117.00	16.50
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	2,240.00	1,744.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,240.00	1,744.40

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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	76,633.26	ADJUSTMENTS	0.00
COVERED CHARGES	70,074.46	CONTRACTUAL ALLOW	65,874.46
NON-COVERD CHARGES	6,558.80	TOTAL MEDICAID LIAB	4,200.00
		LESS: COB	30.00
		LESS: COPAYMENT	165.32
		REIMBURSEMENT	4,004.68
		TOTAL NUMBER OF CLAIMS	84

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	512.00	307.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	722.31	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,864.00	0.00	OTHER THERAPEUTIC SVC	0.00	1,630.30
CT SCAN	3,479.00	2,575.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,107.00	700.00
EKG/ECG	1,572.00	262.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,757.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	228.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	50,779.15	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,054.00	797.50
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	287.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	70,074.46	6,558.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	70,074.46	6,558.80

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

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,900.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,858.00	CONTRACTUAL ALLOW	1,156.44
NON-COVERD CHARGES	42.00	TOTAL MEDICAID LIAB	701.56
		LESS: COB	701.56
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MERIWETHER HEALTHCARE, LLC
 5995 SPRING ST
 WARM SPRINGS,GA 31830-2149

PROVIDER NUMBER
 000001284A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 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	288.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,570.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	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
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	1,858.00	42.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,858.00	42.00

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

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	01/01/16	THROUGH	12/31/16
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

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	01/01/16	THROUGH	12/31/16
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

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,464,235.30	ADJUSTMENTS	185,456.36
COVERED CHARGES	1,424,749.30	CONTRACTUAL ALLOW	796,542.92
NON-COVERD CHARGES	39,486.00	TOTAL MEDICAID LIAB	628,206.38
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	628,206.38

TOTAL NUMBER OF ADMISSIONS 89

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	374		0	142,450.00		3,080.00
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	374		0	142,450.00		3,080.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	374		0	142,450.00		3,080.00

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

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

Run Date: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	371,432.80	0.00	OTHER LAB	5,886.00	0.00
MED/SURG SUPPLY	232,546.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	249,133.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	30,466.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	69,352.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	20,803.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,047.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,501.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	46,974.00	14,518.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	121,035.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	53,064.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,000.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	232.50	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	466.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,936.00
OTHER IMAGING SERVICE	7,410.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	39,032.00	19,952.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	530.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,857.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,532.00	0.00			
			TOTAL ANCILLARY	1,282,299.30	36,406.00
			TOTAL ACCOMODATIONS	142,450.00	3,080.00
			TOTAL CHARGES	1,424,749.30	39,486.00

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

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
616	2015323093140	07/05/15 - 07/13/15	11/23/15	0.00	1,936.00	0.00	0.00	0.00
TOTAL				0.00	1,936.00	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: 08/24/2017
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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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,496,619.23	ADJUSTMENTS	33,595.80
COVERED CHARGES	3,127,696.08	CONTRACTUAL ALLOW	1,690,997.66
NON-COVERD CHARGES	368,923.15	TOTAL MEDICAID LIAB	1,436,698.42
		LESS: COB	472.34
		LESS: COPAYMENT	1,593.00
		REIMBURSEMENT	1,434,633.08
		ALL OTHER	1,295,673.33
		FEE SCHEDULE-LAB	138,873.04
		INJECTABLE DRUGS	86.71
		TOTAL NUMBER OF CLAIMS	5,711

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	97,737.80	95,978.10	OTHER LAB	36,830.00	0.00
MED/SURG SUPPLY	255,333.98	3,541.95	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,611.21	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	188,824.00	10,403.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	118,058.00	22,292.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,849.00	2,893.00	FEE SCHEDULE LAB	914,099.60	127,669.86
EKG/ECG	12,208.00	1,417.00	MRI SERVICES	20,328.00	0.00
IV THERAPY	4,609.00	639.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,009,322.65	29,876.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	17,504.00	4,159.00	FREE STANDING CLINIC	17.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	137,978.00	10,833.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	105,000.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	144.05	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	314.03	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	12,337.00	209.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	3,388.00
OTHER IMAGING SERVICE	21,847.00	1,131.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	33,796.00	15,312.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	8,796.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	551.00	2,749.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	750.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	123,776.00	34,507.00			
			TOTAL ANCILLARY	3,127,696.08	368,923.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,127,696.08	368,923.15

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016040015528	02/04/16 - 02/04/16	02/15/16	0.00	1,694.00	0.00	0.00	0.00
618	2016040015528	02/04/16 - 02/04/16	02/15/16	0.00	1,694.00	0.00	0.00	0.00
TOTAL				0.00	3,388.00	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: 08/24/2017
Run Time: 03:50:32
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	46,177.35	ADJUSTMENTS	0.00
COVERED CHARGES	35,723.25	CONTRACTUAL ALLOW	3,850.76
NON-COVERD CHARGES	10,454.10	TOTAL MEDICAID LIAB	31,872.49
		LESS: COB	31,869.49
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 20

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,953.05	1,420.10	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,019.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	435.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	4,330.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,194.00	1,115.00
EKG/ECG	109.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	152.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,574.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	76.00	141.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,233.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,500.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	579.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	952.00	464.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,720.00	2,984.00			
			TOTAL ANCILLARY	35,723.25	10,454.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	35,723.25	10,454.10

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

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	72,760.80	ADJUSTMENTS	47.00
COVERED CHARGES	70,208.15	CONTRACTUAL ALLOW	64,617.15
NON-COVERD CHARGES	2,552.65	TOTAL MEDICAID LIAB	5,591.00
		LESS: COB	0.00
		LESS: COPAYMENT	237.00
		REIMBURSEMENT	5,354.00
		TOTAL NUMBER OF CLAIMS	118

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,314.00	1,000.65	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,855.15	106.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	88.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,653.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,171.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,765.00	990.00
EKG/ECG	109.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	123.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,200.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	37,810.00	226.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	750.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	81.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	458.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	61.00			
			TOTAL ANCILLARY	70,208.15	2,552.65
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	70,208.15	2,552.65

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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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	318.00	ADJUSTMENTS	0.00
COVERED CHARGES	318.00	CONTRACTUAL ALLOW	137.55
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	180.45
		LESS: COB	177.45
		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

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 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	45.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	318.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	318.00	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

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	43,684.73	ADJUSTMENTS	4,819.45
COVERED CHARGES	36,188.28	CONTRACTUAL ALLOW	16,630.56
NON-COVERD CHARGES	7,496.45	TOTAL MEDICAID LIAB	19,557.72
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	19,554.72
		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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	351.30	5,894.45	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	11,557.98	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	435.00	145.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,194.00	830.00
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	15,268.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,635.00	163.00	FREE STANDING CLINIC	0.00	0.00
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	2,250.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,428.00	464.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	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	36,188.28	7,496.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	36,188.28	7,496.45

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: 08/24/2017
Run Time: 03:50:36
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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	07/01/15	THROUGH	06/30/16
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

GOOD SAMARITAN HOSPITAL INC
 5401 LAKE OCONEE PARKWAY
 GREENSBORO,GA 30642-4232

PROVIDER NUMBER 000001328A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	601,729.20	ADJUSTMENTS	77,464.32
COVERED CHARGES	571,149.20	CONTRACTUAL ALLOW	372,881.16
NON-COVERD CHARGES	30,580.00	TOTAL MEDICAID LIAB	198,268.04
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	198,268.04

TOTAL NUMBER OF ADMISSIONS 34

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	124		0	127,720.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	124		0	127,720.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	124		0	127,720.00		0.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	116,061.20	0.00	OTHER LAB	1,374.00	0.00
MED/SURG SUPPLY	7,071.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	75,891.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,270.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,643.00	25,238.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,688.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,278.00	0.00	MRI SERVICES	7,025.00	0.00
IV THERAPY	7,219.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	28,488.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	18,048.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,518.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,429.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,863.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,384.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,497.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	258.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	66.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	92,691.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	5,342.00
OTHER IMAGING SERVICE	916.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,772.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	12,834.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	145.00	0.00			
			TOTAL ANCILLARY	443,429.20	30,580.00
			TOTAL ACCOMODATIONS	127,720.00	0.00
			TOTAL CHARGES	571,149.20	30,580.00

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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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5915321000574	10/21/15 - 10/26/15	11/23/15	0.00	1,472.00	0.00	0.00	0.00
614	5916183001292	04/06/16 - 04/06/16	07/04/16	0.00	1,472.00	0.00	0.00	0.00
614	5916183001292	04/06/16 - 04/06/16	07/04/16	0.00	2,398.00	0.00	0.00	0.00
TOTAL				0.00	5,342.00	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

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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,628,810.00	ADJUSTMENTS	7,867.35
COVERED CHARGES	1,490,095.45	CONTRACTUAL ALLOW	945,520.70
NON-COVERD CHARGES	138,714.55	TOTAL MEDICAID LIAB	544,574.75
		LESS: COB	3,031.65
		LESS: COPAYMENT	927.00
		REIMBURSEMENT	540,616.10
		ALL OTHER	502,529.90
		FEE SCHEDULE-LAB	33,180.88
		INJECTABLE DRUGS	4,905.32
		TOTAL NUMBER OF CLAIMS	1,188

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,943.69	0.00	OTHER LAB	15,006.00	0.00
MED/SURG SUPPLY	11,120.00	2,507.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	56.00	0.00
RADIOLOGY-DIAGNOSTIC	97,874.00	280.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	235,832.00	17,363.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,744.00	5,955.00	FEE SCHEDULE LAB	265,678.00	13,002.00
EKG/ECG	21,016.00	1,788.00	MRI SERVICES	78,612.00	5,467.00
IV THERAPY	67,183.00	1,499.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	50,198.00	17,839.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,062.00	1,122.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	42,756.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	321,701.00	4,006.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	31,859.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	78,659.76	16,360.55
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	606.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	792.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	616.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	30,101.00	7,561.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,588.00	2,492.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	36,146.00	30,083.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	19,964.00	9,982.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	25,198.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,192.00	0.00			
			TOTAL ANCILLARY	1,490,095.45	138,714.55
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,490,095.45	138,714.55

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

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	35,770.55	ADJUSTMENTS	0.00
COVERED CHARGES	23,587.58	CONTRACTUAL ALLOW	6,054.22
NON-COVERD CHARGES	12,182.97	TOTAL MEDICAID LIAB	17,533.36
		LESS: COB	17,530.36
		LESS: COPAYMENT	3.00
		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

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	479.53	0.00	OTHER LAB	1,024.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	56.00
RADIOLOGY-DIAGNOSTIC	1,704.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,997.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,227.00	85.00
EKG/ECG	298.00	0.00	MRI SERVICES	0.00	4,258.00
IV THERAPY	1,436.00	653.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,868.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,754.05	484.97
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,055.00	1,483.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	742.00	740.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,426.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	23,587.58	12,182.97
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	23,587.58	12,182.97

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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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	133,797.52	ADJUSTMENTS	94.00
COVERED CHARGES	128,330.60	CONTRACTUAL ALLOW	119,180.60
NON-COVERD CHARGES	5,466.92	TOTAL MEDICAID LIAB	9,150.00
		LESS: COB	9.91
		LESS: COPAYMENT	327.00
		REIMBURSEMENT	8,813.09
		TOTAL NUMBER OF CLAIMS	183

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,775.30	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	7,425.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,972.00	1,525.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,949.00	1,332.00
EKG/ECG	1,192.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,417.00	102.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,303.00	66.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	530.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	63,894.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,566.30	619.92
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	837.00	1,292.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	128,330.60	5,466.92
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	128,330.60	5,466.92

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

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,780.36	ADJUSTMENTS	0.00
COVERED CHARGES	5,763.36	CONTRACTUAL ALLOW	3,659.29
NON-COVERD CHARGES	17.00	TOTAL MEDICAID LIAB	2,104.07
		LESS: COB	2,095.07
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	6

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30.81	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	642.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,556.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	891.00	17.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	128.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,221.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	294.55	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	5,763.36	17.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,763.36	17.00

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

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	107,265.47	ADJUSTMENTS	4,979.44
COVERED CHARGES	102,317.71	CONTRACTUAL ALLOW	66,459.48
NON-COVERD CHARGES	4,947.76	TOTAL MEDICAID LIAB	35,858.23
		LESS: COB	0.00
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	35,825.23

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,488.57	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,534.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	0.00
EKG/ECG	298.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	46,394.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	66.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	17,295.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,938.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,786.14	633.76
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	4,314.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	102,317.71	4,947.76
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	102,317.71	4,947.76

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: 08/24/2017
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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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	53,003.00	ADJUSTMENTS	0.00
COVERED CHARGES	53,003.00	CONTRACTUAL ALLOW	20,840.76
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	32,162.24
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	32,162.24

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	13		0	7,821.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	13		0	7,821.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	13		0	7,821.00		0.00

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,878.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,357.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	14,947.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	656.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,630.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	230.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,946.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,604.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,934.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	45,182.00	0.00
			TOTAL ACCOMODATIONS	7,821.00	0.00
			TOTAL CHARGES	53,003.00	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

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	10/01/15	THROUGH	09/30/16
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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,800,798.53	ADJUSTMENTS	26,777.08
COVERED CHARGES	1,686,176.53	CONTRACTUAL ALLOW	1,326,844.59
NON-COVERD CHARGES	114,622.00	TOTAL MEDICAID LIAB	359,331.94
		LESS: COB	409.95
		LESS: COPAYMENT	1,584.00
		REIMBURSEMENT	357,337.99
		ALL OTHER	298,587.58
		FEE SCHEDULE-LAB	52,951.14
		INJECTABLE DRUGS	5,799.27

TOTAL NUMBER OF CLAIMS 2,013

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	90,250.00	0.00	OTHER LAB	6,185.00	0.00
MED/SURG SUPPLY	21,575.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	290.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	154,493.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	220,257.00	66,095.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	82,834.00	15,091.00	FEE SCHEDULE LAB	466,196.42	12,984.00
EKG/ECG	20,866.00	0.00	MRI SERVICES	23,012.00	3,469.00
IV THERAPY	90,487.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	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	31,743.00	2,594.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	248.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	371,254.00	487.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	51,420.11	3,071.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	326.00	1,436.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	269.00	1,500.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	539.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	69.00
OTHER IMAGING SERVICE	42,547.00	4,824.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,731.00	1,925.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,309.00	0.00			
			TOTAL ANCILLARY	1,686,176.53	114,622.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,686,176.53	114,622.00

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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016250068997	08/29/16 - 08/29/16	09/12/16	0.00	69.00	0.00	0.00	0.00
TOTAL				0.00	69.00	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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,344.00	ADJUSTMENTS	0.00
COVERED CHARGES	21,882.00	CONTRACTUAL ALLOW	8,347.30
NON-COVERD CHARGES	462.00	TOTAL MEDICAID LIAB	13,534.70
		LESS: COB	13,531.70
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 20

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	104.00	76.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,600.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,920.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,276.00	93.00
EKG/ECG	407.00	53.00	MRI SERVICES	0.00	0.00
IV THERAPY	408.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	184.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,264.00	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	283.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	240.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL 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	21,882.00	462.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	21,882.00	462.00

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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	46,047.00	ADJUSTMENTS	0.00
COVERED CHARGES	44,844.00	CONTRACTUAL ALLOW	40,894.00
NON-COVERD CHARGES	1,203.00	TOTAL MEDICAID LIAB	3,950.00
		LESS: COB	0.00
		LESS: COPAYMENT	85.75
		REIMBURSEMENT	3,864.25
		TOTAL NUMBER OF CLAIMS	79

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 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	119.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,178.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,636.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,950.00	782.00
EKG/ECG	53.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,695.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	184.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,933.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,755.00	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	311.00	411.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	44,844.00	1,203.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	44,844.00	1,203.00

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	970.00	ADJUSTMENTS	0.00
COVERED CHARGES	970.00	CONTRACTUAL ALLOW	539.53
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	430.47
		LESS: COB	430.47
		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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 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	265.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	204.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	41.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	970.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	970.00	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

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	107,778.00	ADJUSTMENTS	0.00
COVERED CHARGES	107,618.00	CONTRACTUAL ALLOW	87,792.36
NON-COVERD CHARGES	160.00	TOTAL MEDICAID LIAB	19,825.64
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	19,810.64
		TOTAL NUMBER OF CLAIMS	4

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	49,901.00	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	22,725.00	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	34,992.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	107,618.00	160.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	107,618.00	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: 08/24/2017
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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	10/01/15	THROUGH	09/30/16
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: 08/24/2017
 Run Time: 03:51:01
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	160,337.61	ADJUSTMENTS	7,164.34
COVERED CHARGES	159,985.61	CONTRACTUAL ALLOW	85,125.61
NON-COVERD CHARGES	352.00	TOTAL MEDICAID LIAB	74,860.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	74,860.00

TOTAL NUMBER OF ADMISSIONS 16

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	36		0	16,740.00		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	36		0	16,740.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	10		0	9,080.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	10		0	9,080.00		0.00
TOTAL ACCOMODATIONS	46		0	25,820.00		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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,753.34	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,904.61	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	28,220.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,738.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,713.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	960.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	14,263.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,406.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,154.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,851.66	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,234.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	648.00	352.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	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	297.00	0.00			
			TOTAL ANCILLARY	134,165.61	352.00
			TOTAL ACCOMODATIONS	25,820.00	0.00
			TOTAL CHARGES	159,985.61	352.00

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

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

Run Date: 08/24/2017
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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	10/01/15	THROUGH	09/30/16
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: 08/24/2017
Run Time: 03:51:02
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	607,872.70	ADJUSTMENTS	23,728.97
COVERED CHARGES	544,737.93	CONTRACTUAL ALLOW	329,941.59
NON-COVERD CHARGES	63,134.77	TOTAL MEDICAID LIAB	214,796.34
		LESS: COB	1,016.20
		LESS: COPAYMENT	267.00
		REIMBURSEMENT	213,513.14
		ALL OTHER	200,139.70
		FEE SCHEDULE-LAB	11,801.24
		INJECTABLE DRUGS	1,572.20

TOTAL NUMBER OF CLAIMS 553

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: 08/24/2017
 Run Time: 03:51:02
 Page: 5

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,833.88	5,282.40	OTHER LAB	749.00	0.00
MED/SURG SUPPLY	7,118.41	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	19.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	59,794.00	1,346.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	101,052.00	33,907.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	228.03	FEE SCHEDULE LAB	98,036.00	9,671.00
EKG/ECG	9,345.00	810.00	MRI SERVICES	19,815.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,600.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,391.00	393.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	6,895.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	190,201.60	2,158.34	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,110.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,437.04	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	127.00	201.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,400.00	30.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,268.00	1,408.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,341.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,119.00	786.00			
			TOTAL ANCILLARY	544,737.93	63,134.77
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	544,737.93	63,134.77

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,921.32	ADJUSTMENTS	0.00
COVERED CHARGES	4,206.32	CONTRACTUAL ALLOW	1,268.93
NON-COVERD CHARGES	1,715.00	TOTAL MEDICAID LIAB	2,937.39
		LESS: COB	2,934.39
		LESS: COPAYMENT	3.00
		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

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	427.49	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	34.83	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,920.00	1,468.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,408.00	247.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	416.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,206.32	1,715.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,206.32	1,715.00

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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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	63,251.62	ADJUSTMENTS	191.00
COVERED CHARGES	59,131.34	CONTRACTUAL ALLOW	53,431.34
NON-COVERD CHARGES	4,120.28	TOTAL MEDICAID LIAB	5,700.00
		LESS: COB	0.00
		LESS: COPAYMENT	264.00
		REIMBURSEMENT	5,436.00
		TOTAL NUMBER OF CLAIMS	114

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,288.15	2,000.28	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	123.42	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,806.00	286.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,266.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,604.00	1,158.00
EKG/ECG	162.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	48.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	35,229.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,232.77	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	48.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	324.00	676.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	59,131.34	4,120.28
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	59,131.34	4,120.28

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

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	706.20	ADJUSTMENTS	0.00
COVERED CHARGES	554.20	CONTRACTUAL ALLOW	58.38
NON-COVERD CHARGES	152.00	TOTAL MEDICAID LIAB	495.82
		LESS: COB	492.82
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE COUNTY HOSPITAL
 88 MARTIN LUTHER KING JR DR
 FORSYTH,GA 31029-1682

PROVIDER NUMBER
 000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 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	3.20	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	126.00	152.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	425.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	554.20	152.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	554.20	152.00

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

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	10/01/15	THROUGH	09/30/16
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: 08/24/2017
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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	10/01/15	THROUGH	09/30/16
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: 08/24/2017
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

ADVENTIST HEALTH SYSTEM GEORGIA INC
 707 OLD DALTON ELLIJAY RD
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER 000001383A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	891,038.29	ADJUSTMENTS	0.00
COVERED CHARGES	854,716.28	CONTRACTUAL ALLOW	586,531.62
NON-COVERD CHARGES	36,322.01	TOTAL MEDICAID LIAB	268,184.66
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	268,184.66

TOTAL NUMBER OF ADMISSIONS 37

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	100		0	70,052.00		5,812.96
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	100		0	70,052.00		5,812.96
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	100		0	70,052.00		5,812.96

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

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

Run Date: 08/24/2017
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

ADVENTIST HEALTH SYSTEM GEORGIA INC
 707 OLD DALTON ELLIJAY RD
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,533.35	0.00	OTHER LAB	3,512.18	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	215,494.24	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	23,119.36	0.00	OTHER THERAPEUTIC SVC	0.00	1,752.88
CT SCAN	47,822.43	28,756.17	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	46,578.45	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	18,403.50	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	130,717.02	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	61,688.23	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	200,766.87	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	0.00	0.00			
CARDIOLOGY	15,064.26	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	964.39	0.00			
			TOTAL ANCILLARY	784,664.28	30,509.05
			TOTAL ACCOMODATIONS	70,052.00	5,812.96
			TOTAL CHARGES	854,716.28	36,322.01

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

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

Run Date: 08/24/2017
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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

ADVENTIST HEALTH SYSTEM GEORGIA INC
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 12/31/16
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: 08/24/2017
Run Time: 03:51:39
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ADVENTIST HEALTH SYSTEM GEORGIA INC
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,484,860.34	ADJUSTMENTS	43,654.68
COVERED CHARGES	5,082,627.70	CONTRACTUAL ALLOW	4,060,022.83
NON-COVERD CHARGES	402,232.64	TOTAL MEDICAID LIAB	1,022,604.87
		LESS: COB	100.79
		LESS: COPAYMENT	480.00
		REIMBURSEMENT	1,022,024.08
		ALL OTHER	959,272.92
		FEE SCHEDULE-LAB	52,282.06
		INJECTABLE DRUGS	10,469.10
		TOTAL NUMBER OF CLAIMS	1,782

ADVENTIST HEALTH SYSTEM GEORGIA INC
 707 OLD DALTON ELLIJAY RD
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,975.09	10,131.35	OTHER LAB	9,601.75	0.00
MED/SURG SUPPLY	1,594.01	485.74	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	80.00
RADIOLOGY-DIAGNOSTIC	356,670.01	1,757.06	OTHER THERAPEUTIC SVC	0.00	88,327.25
CT SCAN	989,318.44	160,237.56	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	46,187.76	2,976.35	FEE SCHEDULE LAB	1,144,016.37	73,590.91
EKG/ECG	125,486.73	425.16	MRI SERVICES	90,702.31	9,775.16
IV THERAPY	259,485.92	5,908.98	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	25,704.90	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	30,123.64	7,999.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,242.05	957.23	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,642,794.47	7,297.64	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	738.12	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	257,142.11	19,939.43
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	1,326.03	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	1,460.08
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,377.36
OTHER IMAGING SERVICE	15,044.76	3,701.49			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,373.25	4,478.36			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	48,426.01	0.00			
			TOTAL ANCILLARY	5,082,627.70	402,232.64
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,082,627.70	402,232.64

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: 08/24/2017
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ADVENTIST HEALTH SYSTEM GEORGIA INC
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016014078594	12/09/15 - 12/09/15	01/18/16	0.00	1,377.36	0.00	0.00	0.00
TOTAL				0.00	1,377.36	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: 08/24/2017
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SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ADVENTIST HEALTH SYSTEM GEORGIA INC
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	33,257.37	ADJUSTMENTS	0.00
COVERED CHARGES	20,900.17	CONTRACTUAL ALLOW	3,970.67
NON-COVERD CHARGES	12,357.20	TOTAL MEDICAID LIAB	16,929.50
		LESS: COB	16,926.50
		LESS: COPAYMENT	3.00
		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

ADVENTIST HEALTH SYSTEM GEORGIA INC
 707 OLD DALTON ELLIJAY RD
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63.58	448.67	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,117.85	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	4,434.01	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,575.21	540.30
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	699.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	5,599.02	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	178.11	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	960.35	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,831.32	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	470.00	970.18
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	365.02
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	20,900.17	12,357.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	20,900.17	12,357.20

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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ADVENTIST HEALTH SYSTEM GEORGIA INC
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	348,775.03	ADJUSTMENTS	269.08
COVERED CHARGES	333,358.20	CONTRACTUAL ALLOW	316,801.58
NON-COVERD CHARGES	15,416.83	TOTAL MEDICAID LIAB	16,556.62
		LESS: COB	10.68
		LESS: COPAYMENT	561.61
		REIMBURSEMENT	15,984.33
		TOTAL NUMBER OF CLAIMS	296

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

ADVENTIST HEALTH SYSTEM GEORGIA INC
 707 OLD DALTON ELLIJAY RD
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	265.66	387.85	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	80.56	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,453.98	0.00	OTHER THERAPEUTIC SVC	0.00	2,732.92
CT SCAN	37,195.39	5,580.84	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	51,429.72	4,669.11
EKG/ECG	684.54	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,789.70	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	1,239.78	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	208,896.17	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	19,168.35	638.01
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	183.64	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	154.35	1,224.46			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	333,358.20	15,416.83
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	333,358.20	15,416.83

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

ADVENTIST HEALTH SYSTEM GEORGIA INC
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,600.76	ADJUSTMENTS	0.00
COVERED CHARGES	3,573.22	CONTRACTUAL ALLOW	2,859.82
NON-COVERD CHARGES	27.54	TOTAL MEDICAID LIAB	713.40
		LESS: COB	713.40
		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: 08/24/2017
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ADVENTIST HEALTH SYSTEM GEORGIA INC
 707 OLD DALTON ELLIJAY RD
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 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	1,536.65	27.54
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,036.57	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,573.22	27.54
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,573.22	27.54

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

ADVENTIST HEALTH SYSTEM GEORGIA INC
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,534.93	ADJUSTMENTS	0.00
COVERED CHARGES	25,216.85	CONTRACTUAL ALLOW	19,880.87
NON-COVERD CHARGES	4,318.08	TOTAL MEDICAID LIAB	5,335.98
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,335.98

TOTAL NUMBER OF CLAIMS 1

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

ADVENTIST HEALTH SYSTEM GEORGIA INC
 707 OLD DALTON ELLIJAY RD
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	329.00	108.35	OTHER LAB	1,000.59	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,156.58	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,791.46	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	371.93	FEE SCHEDULE LAB	6,980.22	425.55
EKG/ECG	850.32	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,198.49	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	72.25	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	2,593.68	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	594.50	358.48
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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	3,053.77			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,649.76	0.00			
			TOTAL ANCILLARY	25,216.85	4,318.08
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,216.85	4,318.08

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: 08/24/2017
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ADVENTIST HEALTH SYSTEM GEORGIA INC
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/15	THROUGH	12/31/16
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: 08/24/2017
 Run Time: 04:00:29
 Page: 1

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

PIEDMONT NEWTON HOSPITAL
 5126 HOSPITAL DR NE
 COVINGTON,GA 30014-2566

PROVIDER NUMBER 000001394A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,002,944.13	ADJUSTMENTS	19,675.02
COVERED CHARGES	3,927,191.23	CONTRACTUAL ALLOW	2,551,205.27
NON-COVERD CHARGES	75,752.90	TOTAL MEDICAID LIAB	1,375,985.96
		LESS: COB	5,657.02
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,370,328.94

TOTAL NUMBER OF ADMISSIONS 178

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	448	0	282,346.50	0.00
ROUTINE NURSERY	53	0	32,215.80	37,614.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	501	0	314,562.30	37,614.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	154	0	225,132.60	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	154	0	225,132.60	0.00
TOTAL ACCOMODATIONS	655	0	539,694.90	37,614.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

PIEDMONT NEWTON HOSPITAL
 5126 HOSPITAL DR NE
 COVINGTON,GA 30014-2566

PROVIDER NUMBER
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	791,850.08	0.00	OTHER LAB	22,315.85	0.00
MED/SURG SUPPLY	285,721.75	22.10	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	614,470.45	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	63,175.65	0.00	OTHER THERAPEUTIC SVC	0.00	18,920.60
CT SCAN	322,172.50	6,644.55	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	55,435.55	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	24,425.35	0.00	MRI SERVICES	14,389.85	0.00
IV THERAPY	29,402.45	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	220,151.25	885.90	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	38,071.55	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	107,002.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	752.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	21,481.35	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	108,094.40	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	87,613.15	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,410.35	0.00	INJECTABLE DRUGS	108,689.24	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	9,531.05	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	44,577.00	1,143.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	812.28	5,421.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	175,715.73	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	44,805.15	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	60,508.70	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,221.00	5,101.50			
AUDIOLOGY	3,122.55	0.00			
CARDIOLOGY	74,400.05	0.00			
AMBULATORY SURGERY	10,001.35	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,466.10	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	36,710.10	0.00			
			TOTAL ANCILLARY	3,387,496.33	38,138.90
			TOTAL ACCOMODATIONS	539,694.90	37,614.00
			TOTAL CHARGES	3,927,191.23	75,752.90

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT NEWTON HOSPITAL
 5126 HOSPITAL DR NE
 COVINGTON,GA 30014-2566

PROVIDER NUMBER 000001394A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,990.51	ADJUSTMENTS	0.00
COVERED CHARGES	4,990.51	CONTRACTUAL ALLOW	1,568.11
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	3,422.40
		LESS: COB	3,422.40
		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	1,265.50		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2		0	1,265.50		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	2		0	1,265.50		0.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT NEWTON HOSPITAL
 5126 HOSPITAL DR NE
 COVINGTON,GA 30014-2566

PROVIDER NUMBER
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	376.86	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	244.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	667.30	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,266.65	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	1,073.20	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	42.40	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	53.70	0.00			
			TOTAL ANCILLARY	3,725.01	0.00
			TOTAL ACCOMODATIONS	1,265.50	0.00
			TOTAL CHARGES	4,990.51	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: 08/24/2017
Run Time: 04:00:32
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PIEDMONT NEWTON HOSPITAL
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,341,041.88	ADJUSTMENTS	24,229.97
COVERED CHARGES	3,869,249.27	CONTRACTUAL ALLOW	3,161,150.40
NON-COVERD CHARGES	471,792.61	TOTAL MEDICAID LIAB	708,098.87
		LESS: COB	5,546.65
		LESS: COPAYMENT	1,602.51
		REIMBURSEMENT	700,949.71
		ALL OTHER	626,807.45
		FEE SCHEDULE-LAB	57,361.53
		INJECTABLE DRUGS	16,780.73

TOTAL NUMBER OF CLAIMS 1,889

PIEDMONT NEWTON HOSPITAL
 5126 HOSPITAL DR NE
 COVINGTON,GA 30014-2566

PROVIDER NUMBER
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	182,595.28	50.00	OTHER LAB	39,126.55	0.00
MED/SURG SUPPLY	110,472.86	1,691.95	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	27,185.10	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	186,556.45	1,567.10	OTHER THERAPEUTIC SVC	0.00	28,038.15
CT SCAN	704,600.05	62,712.95	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	35,061.65	15,072.10	FEE SCHEDULE LAB	746,339.35	93,491.65
EKG/ECG	49,127.10	1,062.90	MRI SERVICES	106,398.25	23,747.60
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	263,708.88	47,779.67	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	32,189.35	1,952.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	752.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	8,908.85	1,952.85	CAST ROOM	0.00	0.00
EMERGENCY ROOM	828,888.03	140.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	40,766.90	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	140,792.52	102,177.76
RADIOLOGY THERAPEUTIC	18,543.30	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	4,321.15	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	1,790.95	395.06	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	21,257.42	216.35
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	51.20
OTHER IMAGING SERVICE	117,483.50	15,902.15			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,835.10	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	11,959.05	18,966.20			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	46,523.35	23,091.60			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	48,786.15	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	116,786.38	226.87			
			TOTAL ANCILLARY	3,869,249.27	471,792.61
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,869,249.27	471,792.61

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: 08/24/2017
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PIEDMONT NEWTON HOSPITAL
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
406	2216193003396	03/22/16 - 03/22/16	07/18/16	0.00	51.20	0.00	0.00	0.00
TOTAL				0.00	51.20	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: 08/24/2017
Run Time: 04:00:39
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT NEWTON HOSPITAL
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	55,540.02	ADJUSTMENTS	0.00
COVERED CHARGES	33,633.94	CONTRACTUAL ALLOW	23,208.35
NON-COVERD CHARGES	21,906.08	TOTAL MEDICAID LIAB	10,425.59
		LESS: COB	10,416.59
		LESS: COPAYMENT	9.00
		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

PIEDMONT NEWTON HOSPITAL
 5126 HOSPITAL DR NE
 COVINGTON,GA 30014-2566

PROVIDER NUMBER
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,575.54	0.00	OTHER LAB	262.85	0.00
MED/SURG SUPPLY	139.55	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	258.20	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,578.70	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,092.65	15,559.20	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,543.55	430.80
EKG/ECG	77.90	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	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	417.20	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	13,422.04	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	2,143.31	192.53
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	849.30	3,756.35			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	1,308.70			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,080.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,074.85	400.30			
			TOTAL ANCILLARY	33,633.94	21,906.08
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	33,633.94	21,906.08

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

Run Date: 08/24/2017
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Page: 10

PIEDMONT NEWTON HOSPITAL
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	378,308.69	ADJUSTMENTS	323.64
COVERED CHARGES	361,849.97	CONTRACTUAL ALLOW	345,739.25
NON-COVERD CHARGES	16,458.72	TOTAL MEDICAID LIAB	16,110.72
		LESS: COB	0.00
		LESS: COPAYMENT	601.86
		REIMBURSEMENT	15,508.86
		TOTAL NUMBER OF CLAIMS	288

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT NEWTON HOSPITAL
 5126 HOSPITAL DR NE
 COVINGTON,GA 30014-2566

PROVIDER NUMBER
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,312.06	0.00	OTHER LAB	2,100.70	0.00
MED/SURG SUPPLY	484.35	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	3,190.80	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,219.00	0.00	OTHER THERAPEUTIC SVC	0.00	389.00
CT SCAN	94,896.80	5,147.40	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	60,157.40	7,384.05
EKG/ECG	1,417.20	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	407.70	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	158,316.80	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	6,759.76	347.47
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,778.20	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	361,849.97	16,458.72
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	361,849.97	16,458.72

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: 08/24/2017
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PIEDMONT NEWTON HOSPITAL
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,810.55	ADJUSTMENTS	0.00
COVERED CHARGES	1,798.35	CONTRACTUAL ALLOW	1,106.36
NON-COVERD CHARGES	12.20	TOTAL MEDICAID LIAB	691.99
		LESS: COB	691.99
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT NEWTON HOSPITAL
 5126 HOSPITAL DR NE
 COVINGTON,GA 30014-2566

PROVIDER NUMBER
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 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	261.70	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	389.10	12.20
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	67.95	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	1,065.95	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	13.65	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,798.35	12.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,798.35	12.20

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

PIEDMONT NEWTON HOSPITAL
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	167,633.78	ADJUSTMENTS	0.00
COVERED CHARGES	167,071.91	CONTRACTUAL ALLOW	122,710.07
NON-COVERD CHARGES	561.87	TOTAL MEDICAID LIAB	44,361.84
		LESS: COB	0.00
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	44,328.84
		TOTAL NUMBER OF CLAIMS	8

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

PIEDMONT NEWTON HOSPITAL
 5126 HOSPITAL DR NE
 COVINGTON,GA 30014-2566

PROVIDER NUMBER
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,064.43	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,604.25	39.85	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	261.70	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	1,766.30	73.20
EKG/ECG	177.15	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	27,501.70	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,021.95	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	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,791.85	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	102,854.84	448.82
RADIOLOGY THERAPEUTIC	7,663.65	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,494.89	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,869.20	0.00			
			TOTAL ANCILLARY	167,071.91	561.87
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	167,071.91	561.87

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: 08/24/2017
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT NEWTON HOSPITAL
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/16	THROUGH	06/30/16
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: 08/24/2017
 Run Time: 03:54:46
 Page: 1

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	124,979,494.65	ADJUSTMENTS	8,354,878.57
COVERED CHARGES	119,083,407.88	CONTRACTUAL ALLOW	91,959,435.87
NON-COVERD CHARGES	5,896,086.77	TOTAL MEDICAID LIAB	27,123,972.01
		LESS: COB	314,310.29
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	26,809,661.72

TOTAL NUMBER OF ADMISSIONS 5,085

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	9,844		0	10,961,159.00		783,882.00
ROUTINE NURSERY	8,458		0	11,855,216.00		2,954,405.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	18,302		0	22,816,375.00		3,738,287.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,938		0	7,148,838.00		59,310.00
NICU	716		0	4,187,672.00		0.00
PED ICU	2		0	8,679.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,656		0	11,345,189.00		59,310.00
TOTAL ACCOMODATIONS	20,958		0	34,161,564.00		3,797,597.00

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

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

Run Date: 08/24/2017
 Run Time: 03:54:46
 Page: 2

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,914,418.74	186,677.27	OTHER LAB	434,992.00	1,266.00
MED/SURG SUPPLY	4,425,408.57	175,085.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	13,363,939.26	103,664.00	EDUCATION & TRAINING	10,978.00	600.00
RADIOLOGY-DIAGNOSTIC	1,202,238.00	3,982.00	OTHER THERAPEUTIC SVC	0.00	117,091.00
CT SCAN	2,033,894.00	4,648.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	767,331.00	10,171.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	224,763.00	0.00	MRI SERVICES	1,059,370.00	0.00
IV THERAPY	115,664.00	16,087.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,142,135.00	87,536.00	DURABLE MED. EQUIP.	0.00	2,569.00
LABOR/DELIVERY ROOM	8,106,035.00	5,928.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,172,160.00	26,879.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,021,086.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	7,140.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,239,115.00	989.00	SPECIAL SERVICES	0.00	15,142.00
RECOVERY ROOM	1,424,120.00	577.00	DRUG-SPECIFIC/HOME IV	0.00	58,341.50
LABORATORY PATHOLOGIC	1,218,280.00	34,162.00	INJECTABLE DRUGS	20,000,071.81	226,714.50
RADIOLOGY THERAPEUTIC	720,843.00	466.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	603,798.00	7,095.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	243,926.00	948.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	319,855.00	77,762.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	344.00	747.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	399.00	0.00	IMPL DEV CHARGE PATIENTS	486,565.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	714,423.00	67,354.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,829,094.00	802,552.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	241,598.00	58,916.00			
AUDIOLOGY	622,765.00	0.00			
CARDIOLOGY	1,064,639.50	4,540.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	133,938.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	56,517.00	0.00			
			TOTAL ANCILLARY	84,921,843.88	2,098,489.77
			TOTAL ACCOMODATIONS	34,161,564.00	3,797,597.00
			TOTAL CHARGES	119,083,407.88	5,896,086.77

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,527,802.70	ADJUSTMENTS	0.00
COVERED CHARGES	6,997,320.70	CONTRACTUAL ALLOW	3,549,574.82
NON-COVERD CHARGES	530,482.00	TOTAL MEDICAID LIAB	3,447,745.88
		LESS: COB	3,447,745.88
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 156

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	285		0	315,762.00		15,098.00
ROUTINE NURSERY	789		0	2,152,885.00		464,830.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,074		0	2,468,647.00		479,928.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	84		0	288,259.00		0.00
NICU	165		0	982,566.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	249		0	1,270,825.00		0.00
TOTAL ACCOMODATIONS	1,323		0	3,739,472.00		479,928.00

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	570,681.50	0.00	OTHER LAB	39,478.00	0.00
MED/SURG SUPPLY	269,408.00	183.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	394,276.20	0.00	EDUCATION & TRAINING	1,125.00	0.00
RADIOLOGY-DIAGNOSTIC	66,271.00	0.00	OTHER THERAPEUTIC SVC	0.00	2,093.00
CT SCAN	2,644.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	31,564.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,665.00	0.00	MRI SERVICES	3,892.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	188,784.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	362,713.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	626,893.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	36,138.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,249.00	0.00	SPECIAL SERVICES	0.00	48,278.00
RECOVERY ROOM	77,014.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	27,214.00	0.00	INJECTABLE DRUGS	332,739.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	79,936.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	25,046.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	24,577.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	16,092.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	33,372.00	0.00			
CARDIOLOGY	36,859.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,218.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,257,848.70	50,554.00
			TOTAL ACCOMODATIONS	3,739,472.00	479,928.00
			TOTAL CHARGES	6,997,320.70	530,482.00

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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	39,153,786.73	ADJUSTMENTS	1,631,018.67
COVERED CHARGES	35,699,777.61	CONTRACTUAL ALLOW	28,049,604.49
NON-COVERD CHARGES	3,454,009.12	TOTAL MEDICAID LIAB	7,650,173.12
		LESS: COB	48,948.69
		LESS: COPAYMENT	27,367.68
		REIMBURSEMENT	7,573,856.75
		ALL OTHER	4,996,880.56
		FEE SCHEDULE-LAB	724,526.04
		INJECTABLE DRUGS	1,852,450.15

TOTAL NUMBER OF CLAIMS 11,241

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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	440,188.93	6,418.14	OTHER LAB	187,331.00	0.00
MED/SURG SUPPLY	1,009,327.69	10,196.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	3,769.00	EDUCATION & TRAINING	4,872.00	423.00
RADIOLOGY-DIAGNOSTIC	573,516.00	3,309.00	OTHER THERAPEUTIC SVC	0.00	2,203.00
CT SCAN	2,445,367.00	538,702.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	12,111.00	25,242.00	FEE SCHEDULE LAB	10,581,057.59	414,368.50
EKG/ECG	163,511.00	4,995.00	MRI SERVICES	2,028,232.00	193,433.00
IV THERAPY	3,112,752.82	78,484.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,180,135.00	329,551.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	202,021.00	1,091.00	REHAB THERAPY	0.00	2,064.00
RESPIRATORY SERVICES	90,922.00	85.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	488,180.00	10,727.00	AMBULANCE	0.00	0.00
GI SERVICES	48,273.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,483,361.00	42,183.00	SPECIAL SERVICES	0.00	437.00
RECOVERY ROOM	494,989.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	55.96
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,067,151.30	962,927.52
RADIOLOGY THERAPEUTIC	1,061,133.00	48,820.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,772.00	21,401.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,452.00	4,091.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	16,331.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	149,812.00	3,828.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	140,887.00	18,232.00	IMPL DEV CHARGE PATIENTS	161,477.25	33,028.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,658,461.00	535,462.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	639,958.00	3,258.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	102,008.00	56,649.00			
AUDIOLOGY	15,972.00	4,976.00			
CARDIOLOGY	141,777.00	52,956.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,731.00	0.00			
ORGAN ACQUISITION	0.00	4,337.00			
TREATMENT/OBSERV. RM	1,008,038.03	19,976.00			
			TOTAL ANCILLARY	35,699,777.61	3,454,009.12
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	35,699,777.61	3,454,009.12

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
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,820,104.39	ADJUSTMENTS	0.00
COVERED CHARGES	1,103,508.13	CONTRACTUAL ALLOW	392,320.25
NON-COVERD CHARGES	716,596.26	TOTAL MEDICAID LIAB	711,187.88
		LESS: COB	710,722.97
		LESS: COPAYMENT	464.91
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 356

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,512.82	0.00	OTHER LAB	4,221.00	543.00
MED/SURG SUPPLY	57,415.00	313.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	408.00	141.00
RADIOLOGY-DIAGNOSTIC	18,141.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	30,745.00	60,205.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	587.00	FEE SCHEDULE LAB	279,756.00	20,671.00
EKG/ECG	5,328.00	333.00	MRI SERVICES	17,356.00	36,500.00
IV THERAPY	62,702.00	1,947.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	58,879.00	113,480.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	39,849.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,492.00	176.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	44,206.00	631.00	AMBULANCE	0.00	0.00
GI SERVICES	4,169.00	7,140.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	177,738.00	5,356.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	41,561.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	63,513.31	365,771.26
RADIOLOGY THERAPEUTIC	13,708.00	466.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	412.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,486.00	494.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	148.00	0.00	IMPL DEV CHARGE PATIENTS	5,734.00	9,678.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	83,677.00	84,932.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,952.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	2,305.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,545.00	4,149.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	35,266.00	366.00			
			TOTAL ANCILLARY	1,103,508.13	716,596.26
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,103,508.13	716,596.26

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	726,308.39	ADJUSTMENTS	2,983.65
COVERED CHARGES	658,060.74	CONTRACTUAL ALLOW	642,956.94
NON-COVERD CHARGES	68,247.65	TOTAL MEDICAID LIAB	15,103.80
		LESS: COB	0.00
		LESS: COPAYMENT	531.59
		REIMBURSEMENT	14,572.21
		TOTAL NUMBER OF CLAIMS	270

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,029.19	52.57	OTHER LAB	3,798.00	0.00
MED/SURG SUPPLY	13,240.00	265.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	228.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,894.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	47,612.00	4,495.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	162,264.00	15,417.00
EKG/ECG	6,344.00	0.00	MRI SERVICES	0.00	7,784.00
IV THERAPY	2,129.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,433.00	4,164.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,394.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,877.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,681.00	1,681.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	344,432.00	7,003.00	SPECIAL SERVICES	0.00	203.00
RECOVERY ROOM	2,175.00	1,537.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,268.15	582.16
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	399.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	33,909.00	22,208.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,200.00	1,522.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,982.40	1,105.92			
			TOTAL ANCILLARY	658,060.74	68,247.65
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	658,060.74	68,247.65

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	58,743.50	ADJUSTMENTS	0.00
COVERED CHARGES	56,328.50	CONTRACTUAL ALLOW	37,216.51
NON-COVERD CHARGES	2,415.00	TOTAL MEDICAID LIAB	19,111.99
		LESS: COB	19,090.99
		LESS: COPAYMENT	21.00
		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

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	620.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	357.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	389.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,130.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	14,797.00	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	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,535.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,083.00	368.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,820.00	988.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	597.00	854.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	56,328.50	2,415.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	56,328.50	2,415.00

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

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,554,946.06	ADJUSTMENTS	202,329.78
COVERED CHARGES	5,214,552.65	CONTRACTUAL ALLOW	3,767,740.74
NON-COVERD CHARGES	340,393.41	TOTAL MEDICAID LIAB	1,446,811.91
		LESS: COB	29,194.45
		LESS: COPAYMENT	2,326.92
		REIMBURSEMENT	1,415,290.54
		TOTAL NUMBER OF CLAIMS	260

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,323.47	1,447.68	OTHER LAB	3,292.00	0.00
MED/SURG SUPPLY	305,470.64	28,681.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,676.00	14,370.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	41,643.00	15,236.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,998.00	FEE SCHEDULE LAB	494,954.00	11,230.00
EKG/ECG	4,662.00	999.00	MRI SERVICES	40,354.00	7,784.00
IV THERAPY	782,113.00	12,368.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	626,906.00	119,241.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	14,482.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	114,660.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	24,896.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	87,994.00	1,328.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,931,579.91	73,329.73
RADIOLOGY THERAPEUTIC	121,849.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	992.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,768.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,845.00	38.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	294,445.00	20,776.00
LITHOTRIPSY	84,724.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	21,063.00	8,981.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	53,407.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	15,341.00	3,101.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	22,985.00	11,651.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	4,337.00			
TREATMENT/OBSERV. RM	73,887.63	737.00			
			TOTAL ANCILLARY	5,214,552.65	340,393.41
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,214,552.65	340,393.41

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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	513,220.00	ADJUSTMENTS	0.00
COVERED CHARGES	381,115.50	CONTRACTUAL ALLOW	170,399.89
NON-COVERD CHARGES	132,104.50	TOTAL MEDICAID LIAB	210,715.61
		LESS: COB	210,625.61
		LESS: COPAYMENT	90.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,421.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,667.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	5,700.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	287.00	10,149.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	31,385.00	12,158.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,509.00	177.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	42,437.00	15,901.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,486.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,558.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	101,962.50	52,749.50
RADIOLOGY THERAPEUTIC	32,795.00	24,320.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	160.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	108,028.00	9,009.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,105.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	33,214.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	1,781.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	260.00	0.00			
			TOTAL ANCILLARY	381,115.50	132,104.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	381,115.50	132,104.50

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

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

Run Date: 08/24/2017
 Run Time: 03:16:43
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

PHOEBE NORTH
 2000 PALMYRA RD
 ALBANY,GA 31701-1528

PROVIDER NUMBER 000001416A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,346,951.08	ADJUSTMENTS	359,000.18
COVERED CHARGES	6,898,989.73	CONTRACTUAL ALLOW	4,630,292.24
NON-COVERD CHARGES	447,961.35	TOTAL MEDICAID LIAB	2,268,697.49
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,268,697.49

TOTAL NUMBER OF ADMISSIONS 264

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,272		0	669,044.00		61,748.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,272		0	669,044.00		61,748.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	253		0	368,134.00		17,188.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		153	0.00		133,159.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	253		153	368,134.00		150,347.00
TOTAL ACCOMODATIONS	1,525		153	1,037,178.00		212,095.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

PHOEBE NORTH
 2000 PALMYRA RD
 ALBANY,GA 31701-1528

PROVIDER NUMBER
 000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,192,627.66	79,662.53	OTHER LAB	39,456.00	1,001.00
MED/SURG SUPPLY	545,802.86	21,078.31	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	836,553.00	19,694.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	124,681.00	2,347.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	298,658.00	6,536.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	147,550.64	1,231.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	51,708.00	0.00	MRI SERVICES	63,924.00	0.00
IV THERAPY	37,531.00	0.00	PROFESSIONAL FEES	0.00	525.00
OPERATING ROOM	89,058.00	17,207.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	413,099.75	6,553.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	21,477.00	5,204.00	AMBULANCE	0.00	0.00
GI SERVICES	34,635.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	396,537.00	1,382.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,554.00	1,834.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	5,034.00	208.00	INJECTABLE DRUGS	60.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	142,311.37	802.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	21,650.37	903.01	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	14,568.00	2,388.00	PATIENT CONVENIENCE	0.00	0.00
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	22,727.08	598.75
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	4,776.00
OTHER IMAGING SERVICE	45,752.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	40,684.00	53,524.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	43,062.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	107,888.00	5,322.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	6,070.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	97,152.00	2,794.00			
			TOTAL ANCILLARY	5,861,811.73	235,866.35
			TOTAL ACCOMODATIONS	1,037,178.00	212,095.00
			TOTAL CHARGES	6,898,989.73	447,961.35

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: 08/24/2017
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PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/15 THROUGH 07/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016173066183	05/19/16 - 05/29/16	06/27/16	0.00	2,388.00	0.00	0.00	0.00
615	5217051000233	03/15/16 - 05/04/16	02/27/17	0.00	2,388.00	0.00	0.00	0.00
TOTAL				0.00	4,776.00	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: 08/24/2017
Run Time: 03:16:44
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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	08/01/15	THROUGH	07/31/16
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: 08/24/2017
Run Time: 03:16:45
Page: 5

PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/15 THROUGH 07/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,030,468.49	ADJUSTMENTS	30,087.80
COVERED CHARGES	1,905,164.16	CONTRACTUAL ALLOW	1,484,529.97
NON-COVERD CHARGES	125,304.33	TOTAL MEDICAID LIAB	420,634.19
		LESS: COB	0.00
		LESS: COPAYMENT	294.00
		REIMBURSEMENT	420,340.19
		ALL OTHER	390,767.12
		FEE SCHEDULE-LAB	21,033.49
		INJECTABLE DRUGS	8,539.58

TOTAL NUMBER OF CLAIMS 694

PHOEBE NORTH
 2000 PALMYRA RD
 ALBANY,GA 31701-1528

PROVIDER NUMBER
 000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	87,097.84	1,242.31	OTHER LAB	10,104.00	0.00
MED/SURG SUPPLY	81,974.44	3,545.46	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	50.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	87,651.00	673.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	586,565.00	45,936.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	350.03	FEE SCHEDULE LAB	176,441.00	13,083.00
EKG/ECG	16,094.00	1,302.00	MRI SERVICES	7,975.00	0.00
IV THERAPY	44,715.00	1,059.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	75,831.00	5,430.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,272.00	1,951.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,368.00	115.00	AMBULANCE	0.00	0.00
GI SERVICES	1,806.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	532,626.00	3,312.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,138.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	104,550.26	26,005.77
RADIOLOGY THERAPEUTIC	4,435.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	97.01	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	582.00	510.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,035.12	1,385.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,388.00
OTHER IMAGING SERVICE	25,786.00	6,332.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	660.00	3,858.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,091.00	5,091.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	15,697.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	724.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,945.50	1,588.75			
			TOTAL ANCILLARY	1,905,164.16	125,304.33
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,905,164.16	125,304.33

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: 08/24/2017
Run Time: 03:16:45
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PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/15 THROUGH 07/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5916140000687	02/08/16 - 02/08/16	05/23/16	0.00	2,388.00	0.00	0.00	0.00
TOTAL				0.00	2,388.00	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: 08/24/2017
Run Time: 03:16:49
Page: 8

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/15 THROUGH 07/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,628.38	ADJUSTMENTS	0.00
COVERED CHARGES	3,691.38	CONTRACTUAL ALLOW	778.35
NON-COVERD CHARGES	937.00	TOTAL MEDICAID LIAB	2,913.03
		LESS: COB	2,913.03
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3

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

PHOEBE NORTH	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
2000 PALMYRA RD	000001416A	SERVICE DATES	08/01/15	THROUGH	07/31/16
ALBANY,GA 31701-1528		ADMISSION DATES	00/00/00	THROUGH	00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	335.60	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	169.78	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	196.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,093.00	22.00
EKG/ECG	186.00	186.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,534.00	617.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	177.00	112.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,691.38	937.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,691.38	937.00

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: 08/24/2017
Run Time: 03:16:49
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PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/15 THROUGH 07/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	157,935.69	ADJUSTMENTS	0.00
COVERED CHARGES	148,472.11	CONTRACTUAL ALLOW	140,137.05
NON-COVERD CHARGES	9,463.58	TOTAL MEDICAID LIAB	8,335.06
		LESS: COB	0.00
		LESS: COPAYMENT	319.72
		REIMBURSEMENT	8,015.34
		TOTAL NUMBER OF CLAIMS	149

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE NORTH
 2000 PALMYRA RD
 ALBANY,GA 31701-1528

PROVIDER NUMBER
 000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,114.38	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,334.49	0.48	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,926.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,649.00	3,830.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,881.00	2,060.00
EKG/ECG	372.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,185.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	660.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	83,396.00	728.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,983.24	1,038.10
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	2,971.00	1,807.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	148,472.11	9,463.58
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	148,472.11	9,463.58

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

PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/15 THROUGH 07/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	971.00	ADJUSTMENTS	0.00
COVERED CHARGES	971.00	CONTRACTUAL ALLOW	965.00
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	6.00
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		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: 08/24/2017
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE NORTH
 2000 PALMYRA RD
 ALBANY,GA 31701-1528

PROVIDER NUMBER
 000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 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	343.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	617.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	971.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	971.00	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: 08/24/2017
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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	08/01/15	THROUGH	07/31/16
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: 08/24/2017
Run Time: 03:16:50
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	08/01/15	THROUGH	07/31/16
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

SOUTHWEST GEORGIA REGIONAL MEDICAL
 361 RANDOLPH ST
 CUTHBERT,GA 39840-6127

PROVIDER NUMBER 000001427A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	285,244.88	ADJUSTMENTS	32,910.68
COVERED CHARGES	278,665.88	CONTRACTUAL ALLOW	153,927.41
NON-COVERD CHARGES	6,579.00	TOTAL MEDICAID LIAB	124,738.47
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	124,738.47

TOTAL NUMBER OF ADMISSIONS 27

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	64		0	32,182.00		2,378.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	64		0	32,182.00		2,378.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	64		0	32,182.00		2,378.00

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 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,434.59	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	30,688.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	43,929.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,440.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	47,485.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,511.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,712.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,826.00	0.00	PROFESSIONAL FEES	0.00	2,924.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,839.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	29,517.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,447.29	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	418.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	843.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,371.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,353.00	1,277.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,670.00	0.00			
			TOTAL ANCILLARY	246,483.88	4,201.00
			TOTAL ACCOMODATIONS	32,182.00	2,378.00
			TOTAL CHARGES	278,665.88	6,579.00

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

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

Run Date: 08/24/2017
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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	08/01/15	THROUGH	07/31/16
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: 08/24/2017
Run Time: 04:12:49
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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 08/01/15 THROUGH 07/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,143,981.47	ADJUSTMENTS	19,131.42
COVERED CHARGES	1,092,702.47	CONTRACTUAL ALLOW	751,935.62
NON-COVERD CHARGES	51,279.00	TOTAL MEDICAID LIAB	340,766.85
		LESS: COB	1,859.06
		LESS: COPAYMENT	531.00
		REIMBURSEMENT	338,376.79
		ALL OTHER	298,095.87
		FEE SCHEDULE-LAB	29,662.69
		INJECTABLE DRUGS	10,618.23

TOTAL NUMBER OF CLAIMS 911

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: 08/24/2017
 Run Time: 04:12:49
 Page: 5

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 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	50,756.00	0.00	OTHER LAB	663.00	0.00
MED/SURG SUPPLY	61,064.90	360.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	316.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	34,542.00	1,009.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	89,527.00	6,764.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	16,364.00	2,855.00	FEE SCHEDULE LAB	231,573.00	17,643.00
EKG/ECG	30,139.00	696.00	MRI SERVICES	0.00	0.00
IV THERAPY	11,646.00	284.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,386.00	2,060.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,581.00	3,898.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,683.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	330,881.00	6,963.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,275.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	36,824.57	1,226.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,813.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,169.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	224.00	240.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	112,923.00	462.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	756.00
OTHER IMAGING SERVICE	6,557.00	1,531.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,437.00	746.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,905.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	17,173.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	33,670.00	396.00			
			TOTAL ANCILLARY	1,092,702.47	51,279.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,092,702.47	51,279.00

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: 08/24/2017
Run Time: 04:12:49
Page: 6

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 08/01/15 THROUGH 07/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2215287004801	09/02/15 - 09/09/15	10/19/15	0.00	54.00	0.00	0.00	0.00
780	2216011009364	12/09/15 - 12/09/15	01/18/16	0.00	54.00	0.00	0.00	0.00
780	5916021001597	10/14/15 - 10/14/15	01/25/16	0.00	54.00	0.00	0.00	0.00
780	2216033005710	12/09/15 - 12/09/15	02/08/16	0.00	54.00	0.00	0.00	0.00
780	2216047001494	01/14/16 - 01/14/16	02/22/16	0.00	54.00	0.00	0.00	0.00
780	2216060005029	01/14/16 - 01/14/16	03/07/16	0.00	54.00	0.00	0.00	0.00
780	2216104003274	03/09/16 - 03/09/16	04/18/16	0.00	54.00	0.00	0.00	0.00
780	2216137005767	04/13/16 - 04/13/16	05/23/16	0.00	54.00	0.00	0.00	0.00
780	2216137005867	04/13/16 - 04/13/16	05/23/16	0.00	54.00	0.00	0.00	0.00
780	2216137006094	04/13/16 - 04/13/16	05/23/16	0.00	54.00	0.00	0.00	0.00
780	2216167005785	05/11/16 - 05/11/16	06/20/16	0.00	54.00	0.00	0.00	0.00
780	2216167005953	05/11/16 - 05/11/16	06/20/16	0.00	54.00	0.00	0.00	0.00
780	2216167006237	05/11/16 - 05/11/16	06/20/16	0.00	54.00	0.00	0.00	0.00
780	2216200002542	06/08/16 - 06/08/16	07/25/16	0.00	54.00	0.00	0.00	0.00
TOTAL				0.00	756.00	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

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 08/01/15 THROUGH 07/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,428.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,428.00	CONTRACTUAL ALLOW	835.12
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1,592.88
		LESS: COB	1,592.88
		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

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 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	150.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	112.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,148.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,428.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,428.00	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: 08/24/2017
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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 08/01/15 THROUGH 07/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	45,962.42	ADJUSTMENTS	0.00
COVERED CHARGES	45,367.42	CONTRACTUAL ALLOW	42,351.42
NON-COVERD CHARGES	595.00	TOTAL MEDICAID LIAB	3,016.00
		LESS: COB	0.00
		LESS: COPAYMENT	99.00
		REIMBURSEMENT	2,917.00
		TOTAL NUMBER OF CLAIMS	65

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

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

Run Date: 08/24/2017
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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 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,714.42	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	654.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,392.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,770.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,322.00	516.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	58.00	79.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	32,612.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	845.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	45,367.42	595.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	45,367.42	595.00

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: 08/24/2017
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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	08/01/15	THROUGH	07/31/16
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

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	08/01/15	THROUGH	07/31/16
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: 08/24/2017
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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	08/01/15	THROUGH	07/31/16
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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,716,274.21	ADJUSTMENTS	357,116.76
COVERED CHARGES	9,688,898.21	CONTRACTUAL ALLOW	7,513,392.08
NON-COVERD CHARGES	27,376.00	TOTAL MEDICAID LIAB	2,175,506.13
		LESS: COB	9,215.01
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,166,291.12

TOTAL NUMBER OF ADMISSIONS 281

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	464		0	543,344.00		27,376.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	464		0	543,344.00		27,376.00
SPECIAL CARE SERVICES						
CCU	508		0	1,167,470.00		0.00
ICU	131		0	431,189.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	639		0	1,598,659.00		0.00
TOTAL ACCOMODATIONS	1,103		0	2,142,003.00		27,376.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	814,350.25	0.00	OTHER LAB	76,850.00	0.00
MED/SURG SUPPLY	295,207.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,571,622.00	0.00	EDUCATION & TRAINING	240.00	0.00
RADIOLOGY-DIAGNOSTIC	236,520.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	794,705.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	34,038.06	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	137,676.00	0.00	MRI SERVICES	111,538.00	0.00
IV THERAPY	216,769.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	286,732.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,008,651.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	136,723.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	694,267.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	45,087.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	47,350.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	108,124.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,068.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	49,960.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,774.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	10,200.00	0.00	IMPL DEV CHARGE PATIENTS	31,172.99	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	66,496.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	97,248.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	129,994.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	470,534.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	6,376.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	55,622.31	0.00			
			TOTAL ANCILLARY	7,546,895.21	0.00
			TOTAL ACCOMODATIONS	2,142,003.00	27,376.00
			TOTAL CHARGES	9,688,898.21	27,376.00

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

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

Run Date: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	42,299.50	ADJUSTMENTS	0.00
COVERED CHARGES	42,299.50	CONTRACTUAL ALLOW	12,939.85
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	29,359.65
		LESS: COB	29,359.65
		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	3,279.00		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	1		0	3,279.00		0.00
TOTAL ACCOMODATIONS	1		0	3,279.00		0.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,389.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,865.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,242.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	486.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,926.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	447.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,173.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	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	3,056.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,373.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,691.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	264.00	0.00			
			TOTAL ANCILLARY	39,020.50	0.00
			TOTAL ACCOMODATIONS	3,279.00	0.00
			TOTAL CHARGES	42,299.50	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

Run Date: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,238,836.02	ADJUSTMENTS	141,738.44
COVERED CHARGES	11,535,256.58	CONTRACTUAL ALLOW	10,077,823.94
NON-COVERD CHARGES	1,703,579.44	TOTAL MEDICAID LIAB	1,457,432.64
		LESS: COB	26,030.08
		LESS: COPAYMENT	2,373.00
		REIMBURSEMENT	1,429,029.56
		ALL OTHER	1,333,290.71
		FEE SCHEDULE-LAB	84,238.85
		INJECTABLE DRUGS	11,500.00

TOTAL NUMBER OF CLAIMS 3,294

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	250,680.00	10,059.50	OTHER LAB	155,047.00	0.00
MED/SURG SUPPLY	142,959.70	6,468.96	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	120.00
RADIOLOGY-DIAGNOSTIC	802,804.00	1,373.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,002,484.00	392,393.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	32,532.00	27,925.00	FEE SCHEDULE LAB	1,672,234.00	86,728.00
EKG/ECG	211,667.00	5,811.00	MRI SERVICES	376,154.00	75,153.00
IV THERAPY	558,688.00	554.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	318,323.00	45,603.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	68,582.00	54,643.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	193,550.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,214,098.00	7,425.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	136,156.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	80,231.00	225,093.00
RADIOLOGY THERAPEUTIC	504,329.00	529,905.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,315.00	857.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	5,988.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	9,211.00	4,773.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	21,135.00	57,165.00	IMPL DEV CHARGE PATIENTS	27,606.80	10,259.68
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,571.00
OTHER IMAGING SERVICE	256,861.00	52,321.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	15,722.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	63,805.00	56,724.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	136,231.00	40,528.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	169,801.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	112,050.08	3,138.30			
			TOTAL ANCILLARY	11,535,256.58	1,703,579.44
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,535,256.58	1,703,579.44

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

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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
616	2016012039715	10/29/15 - 10/29/15	01/18/16	0.00	2,571.00	0.00	0.00	0.00
TOTAL				0.00	2,571.00	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

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	300,091.87	ADJUSTMENTS	0.00
COVERED CHARGES	254,611.62	CONTRACTUAL ALLOW	109,187.78
NON-COVERD CHARGES	45,480.25	TOTAL MEDICAID LIAB	145,423.84
		LESS: COB	145,399.67
		LESS: COPAYMENT	24.17
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 81

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,064.00	1,531.00	OTHER LAB	7,239.00	0.00
MED/SURG SUPPLY	4,980.84	68.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,756.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,268.00	25,516.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,124.00	2,563.00	FEE SCHEDULE LAB	40,387.00	3,540.00
EKG/ECG	5,364.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	12,036.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	19,585.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,390.00	2,277.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,680.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	87,052.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,187.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	922.50	468.25
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	111.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	555.00	1,110.00	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	6,207.00	6,909.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,253.00	787.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,561.28	0.00			
			TOTAL ANCILLARY	254,611.62	45,480.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	254,611.62	45,480.25

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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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	872,824.33	ADJUSTMENTS	491.46
COVERED CHARGES	823,572.33	CONTRACTUAL ALLOW	798,627.66
NON-COVERD CHARGES	49,252.00	TOTAL MEDICAID LIAB	24,944.67
		LESS: COB	1,449.87
		LESS: COPAYMENT	619.58
		REIMBURSEMENT	22,875.22
		TOTAL NUMBER OF CLAIMS	420

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,768.00	405.00	OTHER LAB	16,343.00	0.00
MED/SURG SUPPLY	1,908.00	577.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	50,311.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	71,782.00	12,308.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	161,375.00	7,564.00
EKG/ECG	7,599.00	0.00	MRI SERVICES	10,624.00	9,467.00
IV THERAPY	41,116.00	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	834.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	411,728.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,396.25	655.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	2,415.00	4,440.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	29,054.00	13,836.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,220.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,099.08	0.00			
			TOTAL ANCILLARY	823,572.33	49,252.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	823,572.33	49,252.00

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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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,726.50	ADJUSTMENTS	0.00
COVERED CHARGES	17,698.50	CONTRACTUAL ALLOW	11,414.55
NON-COVERD CHARGES	28.00	TOTAL MEDICAID LIAB	6,283.95
		LESS: COB	6,280.95
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	11

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	296.50	0.00	OTHER LAB	1,468.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,129.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,081.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,309.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,415.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	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	17,698.50	28.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,698.50	28.00

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: 08/24/2017
Run Time: 03:59:19
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	328,050.50	ADJUSTMENTS	0.00
COVERED CHARGES	325,193.25	CONTRACTUAL ALLOW	286,971.15
NON-COVERD CHARGES	2,857.25	TOTAL MEDICAID LIAB	38,222.10
		LESS: COB	0.00
		LESS: COPAYMENT	150.00
		REIMBURSEMENT	38,072.10

TOTAL NUMBER OF CLAIMS 7

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	962.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	519.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	486.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,232.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,194.00	0.00
EKG/ECG	447.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,319.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,072.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	97,575.75	2,357.25
RADIOLOGY THERAPEUTIC	213,386.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	500.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	325,193.25	2,857.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	325,193.25	2,857.25

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: 08/24/2017
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Page: 16

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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
 Run Time: 03:43:05
 Page: 1

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	584,693.85	ADJUSTMENTS	13,788.14
COVERED CHARGES	535,857.85	CONTRACTUAL ALLOW	233,863.83
NON-COVERD CHARGES	48,836.00	TOTAL MEDICAID LIAB	301,994.02
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	301,994.02

TOTAL NUMBER OF ADMISSIONS 61

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	189		0	83,160.00		48,195.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	189		0	83,160.00		48,195.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	189		0	83,160.00		48,195.00

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	140,478.52	0.00	OTHER LAB	2,794.00	0.00
MED/SURG SUPPLY	14,104.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	88,954.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,438.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	31,953.00	641.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	207.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,218.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	20,541.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,222.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	16,519.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,106.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,541.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,059.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	300.00	0.00	INJECTABLE DRUGS	69,929.33	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	677.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	12,634.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,435.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,588.00	0.00			
			TOTAL ANCILLARY	452,697.85	641.00
			TOTAL ACCOMODATIONS	83,160.00	48,195.00
			TOTAL CHARGES	535,857.85	48,836.00

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

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

Run Date: 08/24/2017
 Run Time: 03:43:06
 Page: 3

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,599.69	ADJUSTMENTS	0.00
COVERED CHARGES	19,079.69	CONTRACTUAL ALLOW	3,482.11
NON-COVERD CHARGES	2,520.00	TOTAL MEDICAID LIAB	15,597.58
		LESS: COB	15,597.58
		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	3,040.00		2,520.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	8		0	3,040.00		2,520.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	8		0	3,040.00		2,520.00

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,387.23	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	413.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,153.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	330.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,392.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	222.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,572.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,569.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,256.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,745.46	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	16,039.69	0.00
			TOTAL ACCOMODATIONS	3,040.00	2,520.00
			TOTAL CHARGES	19,079.69	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: 08/24/2017
Run Time: 03:43:06
Page: 5

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,266,763.50	ADJUSTMENTS	77,505.59
COVERED CHARGES	2,097,364.91	CONTRACTUAL ALLOW	1,377,002.89
NON-COVERD CHARGES	169,398.59	TOTAL MEDICAID LIAB	720,362.02
		LESS: COB	1,395.93
		LESS: COPAYMENT	1,206.00
		REIMBURSEMENT	717,760.09
		ALL OTHER	649,600.61
		FEE SCHEDULE-LAB	63,138.71
		INJECTABLE DRUGS	5,020.77

TOTAL NUMBER OF CLAIMS 1,785

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	140,117.21	0.00	OTHER LAB	76,169.00	0.00
MED/SURG SUPPLY	4,224.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,038.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	124,577.00	732.00	OTHER THERAPEUTIC SVC	0.00	420.00
CT SCAN	278,929.00	82,121.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,662.00	390.00	FEE SCHEDULE LAB	483,742.00	27,268.00
EKG/ECG	18,461.00	111.00	MRI SERVICES	11,137.00	0.00
IV THERAPY	154,020.00	1,132.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	130,562.35	37,354.65	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	14,074.00	4,369.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	46,736.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	447,603.00	44.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	41,074.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	49,473.35	4,266.94
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,280.00	1,001.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	66.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	55,418.00	7,727.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,007.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,861.00	1,287.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,238.00	71.00			
			TOTAL ANCILLARY	2,097,364.91	169,398.59
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,097,364.91	169,398.59

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

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,314.89	ADJUSTMENTS	0.00
COVERED CHARGES	13,390.57	CONTRACTUAL ALLOW	8,496.98
NON-COVERD CHARGES	2,924.32	TOTAL MEDICAID LIAB	4,893.59
		LESS: COB	4,884.59
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 16

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,202.23	0.00	OTHER LAB	949.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	791.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,610.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,317.00	95.00
EKG/ECG	111.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	768.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	746.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,923.00	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	676.34	24.32
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	653.00	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	13,390.57	2,924.32
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,390.57	2,924.32

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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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	123,537.62	ADJUSTMENTS	623.00
COVERED CHARGES	118,315.79	CONTRACTUAL ALLOW	110,365.79
NON-COVERD CHARGES	5,221.83	TOTAL MEDICAID LIAB	7,950.00
		LESS: COB	0.00
		LESS: COPAYMENT	343.51
		REIMBURSEMENT	7,606.49
		TOTAL NUMBER OF CLAIMS	159

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

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,193.81	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	85.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,845.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,769.00	2,730.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	21,112.50	2,344.00
EKG/ECG	888.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,953.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	106.00	0.00	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	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	52,511.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,135.48	147.83
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	341.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	118,315.79	5,221.83
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	118,315.79	5,221.83

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

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,765.86	ADJUSTMENTS	0.00
COVERED CHARGES	4,746.86	CONTRACTUAL ALLOW	2,521.36
NON-COVERD CHARGES	19.00	TOTAL MEDICAID LIAB	2,225.50
		LESS: COB	2,222.50
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	897.86	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	165.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,193.00	19.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	715.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,729.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	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	4,746.86	19.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,746.86	19.00

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

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	10/01/15	THROUGH	09/30/16
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: 08/24/2017
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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	10/01/15	THROUGH	09/30/16
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

PERRY HOSPITAL
 1120 MORNINGSIDE DR
 PERRY,GA 31069-2906

PROVIDER NUMBER
 000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	972,315.40	ADJUSTMENTS	31,072.30
COVERED CHARGES	945,367.90	CONTRACTUAL ALLOW	542,875.45
NON-COVERD CHARGES	26,947.50	TOTAL MEDICAID LIAB	402,492.45
		LESS: COB	11,619.91
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	390,872.54

TOTAL NUMBER OF ADMISSIONS 55

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	182		0	150,906.00		26,544.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	182		0	150,906.00		26,544.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	25		0	62,500.00		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	25		0	62,500.00		0.00
TOTAL ACCOMODATIONS	207		0	213,406.00		26,544.00

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

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

Run Date: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	43,492.02	0.00	OTHER LAB	2,505.72	0.00
MED/SURG SUPPLY	22,318.32	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	74,272.14	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,794.79	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,500.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	21,803.77	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	23,840.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,188.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	176,185.18	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	48,439.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	39,600.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	94,698.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,982.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	519.36	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	163.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	65,146.14	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,088.10	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	12,075.18	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	904.56	403.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	45,522.12	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,923.00	0.00			
			TOTAL ANCILLARY	731,961.90	403.50
			TOTAL ACCOMODATIONS	213,406.00	26,544.00
			TOTAL CHARGES	945,367.90	26,947.50

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

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/16	THROUGH	12/31/16
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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,439,770.98	ADJUSTMENTS	41,976.24
COVERED CHARGES	2,337,254.41	CONTRACTUAL ALLOW	1,902,273.98
NON-COVERD CHARGES	102,516.57	TOTAL MEDICAID LIAB	434,980.43
		LESS: COB	1,327.50
		LESS: COPAYMENT	1,162.21
		REIMBURSEMENT	432,490.72
		ALL OTHER	381,737.86
		FEE SCHEDULE-LAB	46,142.54
		INJECTABLE DRUGS	4,610.32
		TOTAL NUMBER OF CLAIMS	1,332

PERRY HOSPITAL
 1120 MORNINGSIDE DR
 PERRY,GA 31069-2906

PROVIDER NUMBER
 000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,107.92	0.00	OTHER LAB	55,547.08	0.00
MED/SURG SUPPLY	20,327.52	131.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	78,521.37	1,452.38	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	115,000.00	4,500.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	298.38	FEE SCHEDULE LAB	174,878.55	9,644.49
EKG/ECG	38,410.00	0.00	MRI SERVICES	20,000.00	1,000.00
IV THERAPY	100,732.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	165,620.26	67,195.78	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	25,680.00	1,884.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	37,800.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,343,676.50	196.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	41,640.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,982.14	7,889.04
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	99.60	972.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	612.71	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	35,346.87	2,923.34			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,704.33	2,162.13			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	40,802.04	2,266.78			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,126.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	17,638.52	0.00			
			TOTAL ANCILLARY	2,337,254.41	102,516.57
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,337,254.41	102,516.57

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

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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	53,692.39	ADJUSTMENTS	0.00
COVERED CHARGES	50,785.47	CONTRACTUAL ALLOW	27,889.52
NON-COVERD CHARGES	2,906.92	TOTAL MEDICAID LIAB	22,895.95
		LESS: COB	22,865.75
		LESS: COPAYMENT	30.20
		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

PERRY HOSPITAL
 1120 MORNINGSIDE DR
 PERRY,GA 31069-2906

PROVIDER NUMBER
 000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	46.43	0.00	OTHER LAB	10,890.48	0.00
MED/SURG SUPPLY	108.46	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,818.63	0.00	OTHER THERAPEUTIC SVC	0.00	398.40
CT SCAN	750.00	750.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,851.93	72.00
EKG/ECG	894.00	0.00	MRI SERVICES	1,000.00	0.00
IV THERAPY	550.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,032.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	30,500.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	257.44	135.51
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	1,085.60	417.62			
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	1,133.39			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	50,785.47	2,906.92
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	50,785.47	2,906.92

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

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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	104,955.04	ADJUSTMENTS	105.88
COVERED CHARGES	104,873.86	CONTRACTUAL ALLOW	101,293.70
NON-COVERD CHARGES	81.18	TOTAL MEDICAID LIAB	3,580.16
		LESS: COB	0.00
		LESS: COPAYMENT	90.00
		REIMBURSEMENT	3,490.16
		TOTAL NUMBER OF CLAIMS	64

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,970.69	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,250.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,481.77	81.18
EKG/ECG	596.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	730.50	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	303.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	93,900.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	202.28	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	417.62	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	104,873.86	81.18
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	104,873.86	81.18

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

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,288.36	ADJUSTMENTS	0.00
COVERED CHARGES	10,255.68	CONTRACTUAL ALLOW	5,291.18
NON-COVERD CHARGES	32.68	TOTAL MEDICAID LIAB	4,964.50
		LESS: COB	4,955.50
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 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	128.38	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	881.04	27.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	111.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,100.00	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	35.26	5.68
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	10,255.68	32.68
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,255.68	32.68

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

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/16	THROUGH	12/31/16
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: 08/24/2017
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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	01/01/16	THROUGH	12/31/16
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: 08/24/2017
 Run Time: 03:14:28
 Page: 1

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
 417 W 3RD AVE
 ALBANY,GA 31701-1943

PROVIDER NUMBER 000001482A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	70,746,447.66	ADJUSTMENTS	5,174,542.51
COVERED CHARGES	67,847,307.98	CONTRACTUAL ALLOW	45,386,160.26
NON-COVERD CHARGES	2,899,139.68	TOTAL MEDICAID LIAB	22,461,147.72
		LESS: COB	95,714.18
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	22,365,433.54

TOTAL NUMBER OF ADMISSIONS 2,062

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	9,318		0	4,550,419.01		1,609,966.00
ROUTINE NURSERY	1,047		0	535,700.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	10,365		0	5,086,119.01		1,609,966.00
SPECIAL CARE SERVICES						
CCU	73		0	98,406.00		0.00
ICU	1,802		0	2,828,913.00		1,590.00
NICU	838		0	1,570,656.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		67	0.00		60,284.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,713		67	4,497,975.00		61,874.00
TOTAL ACCOMODATIONS	13,078		67	9,584,094.01		1,671,840.00

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

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

Run Date: 08/24/2017
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
 417 W 3RD AVE
 ALBANY,GA 31701-1943

PROVIDER NUMBER
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,799,783.33	15,332.44	OTHER LAB	330,518.00	0.00
MED/SURG SUPPLY	5,937,976.53	130,926.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,774,303.79	56,976.00	EDUCATION & TRAINING	114.00	0.00
RADIOLOGY-DIAGNOSTIC	1,020,681.00	2,058.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,891,837.00	136,384.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	530,615.55	192.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	280,696.00	0.00	MRI SERVICES	571,989.00	0.00
IV THERAPY	258,301.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,112,840.00	48,217.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	197,820.18	0.00	REHAB THERAPY	452.00	0.00
RESPIRATORY SERVICES	3,365,675.75	14,568.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,224,201.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	270,786.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,871,913.00	4,245.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,046,058.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	122,753.00	0.00	INJECTABLE DRUGS	357,279.00	0.00
RADIOLOGY THERAPEUTIC	410,180.26	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	311,032.80	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	107,194.82	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	26,267.00	3,344.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	162.00	33,508.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	122,288.00	0.00	IMPL DEV CHARGE PATIENTS	3,572,207.99	323.39
LITHOTRIpsy	19,226.00	0.00	NO CC/INVALID REV CODE	0.00	35,169.00
OTHER IMAGING SERVICE	268,137.00	5,828.00			
BLOOD	0.00	987.00			
BLOOD STORAGE & PRO.	606,954.00	718,801.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	193,937.00	0.00			
AUDIOLOGY	65,192.00	0.00			
CARDIOLOGY	1,736,852.00	13,606.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	64,604.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	792,385.47	6,834.00			
			TOTAL ANCILLARY	58,263,213.97	1,227,299.68
			TOTAL ACCOMODATIONS	9,584,094.01	1,671,840.00
			TOTAL CHARGES	67,847,307.98	2,899,139.68

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
 417 W 3RD AVE
 ALBANY,GA 31701-1943

PROVIDER NUMBER
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015353002866	10/23/15 - 12/08/15	12/28/15	0.00	2,388.00	0.00	0.00	0.00
615	5215362010840	08/02/15 - 08/17/15	02/22/16	0.00	2,171.00	0.00	0.00	0.00
615	5215363002184	08/13/15 - 08/14/15	02/22/16	0.00	2,171.00	0.00	0.00	0.00
615	2216105006033	10/29/15 - 11/25/15	04/18/16	0.00	2,388.00	0.00	0.00	0.00
615	2216124002240	03/21/16 - 03/23/16	05/09/16	0.00	4,776.00	0.00	0.00	0.00
615	2016127015501	09/20/15 - 09/23/15	05/09/16	0.00	2,388.00	0.00	0.00	0.00
615	2016155075356	02/15/16 - 02/18/16	06/13/16	0.00	2,388.00	0.00	0.00	0.00
615	2016160068973	05/30/16 - 06/03/16	06/13/16	0.00	2,388.00	0.00	0.00	0.00
615	2016167076177	05/26/16 - 06/10/16	06/20/16	0.00	2,388.00	0.00	0.00	0.00
615	2116188000011	01/05/16 - 01/08/16	08/08/16	0.00	2,388.00	0.00	2,515.30	0.00
615	2216221000490	06/29/16 - 07/05/16	08/15/16	0.00	2,388.00	0.00	0.00	0.00
615	2016245000629	08/17/15 - 08/20/15	09/05/16	0.00	2,171.00	0.00	0.00	0.00
615	2017067072846	05/01/16 - 05/09/16	03/13/17	0.00	2,388.00	0.00	0.00	0.00
615	5217125005973	06/29/16 - 09/07/16	05/15/17	0.00	2,388.00	0.00	0.00	0.00
TOTAL				0.00	35,169.00	0.00	2,515.30	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: 08/24/2017
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SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
 417 W 3RD AVE
 ALBANY,GA 31701-1943

PROVIDER NUMBER
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	570,355.80	ADJUSTMENTS	0.00
COVERED CHARGES	563,292.78	CONTRACTUAL ALLOW	134,137.71
NON-COVERD CHARGES	7,063.02	TOTAL MEDICAID LIAB	429,155.07
		LESS: COB	429,155.07
		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	31		0	16,585.00		813.00
ROUTINE NURSERY	14		0	8,520.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	45		0	25,105.00		813.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	16		0	30,348.00		0.00
NICU	7		0	13,475.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	23		0	43,823.00		0.00
TOTAL ACCOMODATIONS	68		0	68,928.00		813.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
 417 W 3RD AVE
 ALBANY,GA 31701-1943

PROVIDER NUMBER
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	222,768.29	0.00	OTHER LAB	1,160.00	0.00
MED/SURG SUPPLY	46,504.23	28.02	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	45,628.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,673.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,471.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	194.01	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,674.00	0.00	MRI SERVICES	5,221.00	0.00
IV THERAPY	3,220.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	37,560.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,037.87	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	37,027.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,097.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,300.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,546.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,752.00	0.00	INJECTABLE DRUGS	332.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	645.01	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	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	0.00	0.00	IMPL DEV CHARGE PATIENTS	664.37	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,294.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,311.00	5,922.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	770.00	0.00			
CARDIOLOGY	1,951.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,518.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,046.00	0.00			
			TOTAL ANCILLARY	494,364.78	6,250.02
			TOTAL ACCOMODATIONS	68,928.00	813.00
			TOTAL CHARGES	563,292.78	7,063.02

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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PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/15 THROUGH 07/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	42,214,387.97	ADJUSTMENTS	1,040,117.75
COVERED CHARGES	36,431,884.03	CONTRACTUAL ALLOW	28,572,721.59
NON-COVERD CHARGES	5,782,503.94	TOTAL MEDICAID LIAB	7,859,162.44
		LESS: COB	13,829.73
		LESS: COPAYMENT	30,725.64
		REIMBURSEMENT	7,814,607.07
		ALL OTHER	6,345,489.35
		FEE SCHEDULE-LAB	501,050.86
		INJECTABLE DRUGS	968,066.86

TOTAL NUMBER OF CLAIMS 17,463

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: 08/24/2017
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PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
 417 W 3RD AVE
 ALBANY,GA 31701-1943

PROVIDER NUMBER
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,801,252.21	152,721.27	OTHER LAB	186,233.00	1,670.00
MED/SURG SUPPLY	2,158,355.64	361,882.34	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,716.04	EDUCATION & TRAINING	303.00	77.00
RADIOLOGY-DIAGNOSTIC	991,665.00	42,313.00	OTHER THERAPEUTIC SVC	0.00	1,162.00
CT SCAN	1,919,556.00	288,999.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	62,909.00	12,669.39	FEE SCHEDULE LAB	2,669,377.91	181,347.60
EKG/ECG	332,641.00	20,292.00	MRI SERVICES	692,492.00	59,628.00
IV THERAPY	1,345,677.00	50,031.00	PROFESSIONAL FEES	0.00	218.00
OPERATING ROOM	2,759,433.05	668,388.44	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	22,144.00	938.00	REHAB THERAPY	0.00	7,990.00
RESPIRATORY SERVICES	163,727.00	62,715.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	833,563.00	416.00	AMBULANCE	0.00	0.00
GI SERVICES	736,853.50	94,902.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,123,169.19	268,294.47	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,718,742.00	9,275.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	65.00	INJECTABLE DRUGS	7,188,311.95	2,390,808.42
RADIOLOGY THERAPEUTIC	2,029,923.86	265,657.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,611.00	1,667.08	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,026.00	15,535.42	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	666,842.00	67,268.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	169,870.00	0.00	IMPL DEV CHARGE PATIENTS	310,262.25	207,029.69
LITHOTRIPSY	66,872.00	0.00	NO CC/INVALID REV CODE	0.00	9,433.00
OTHER IMAGING SERVICE	704,701.49	56,009.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	142,562.00	157,083.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	393,692.00	90,427.00			
AUDIOLOGY	2,388.00	322.00			
CARDIOLOGY	505,790.00	180,816.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	334,557.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	384,380.98	52,737.28			
			TOTAL ANCILLARY	36,431,884.03	5,782,503.94
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	36,431,884.03	5,782,503.94

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: 08/24/2017
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PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
 417 W 3RD AVE
 ALBANY,GA 31701-1943

PROVIDER NUMBER
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016028002853	12/03/15 - 12/03/15	02/01/16	0.00	2,388.00	0.00	0.00	0.00
615	2016097009803	03/16/16 - 03/16/16	04/11/16	0.00	2,388.00	0.00	0.00	0.00
8369	5916137001424	03/14/16 - 03/14/16	01/01/00	0.00	70.00	0.00	0.00	0.00
696	5916174000674	04/24/16 - 04/25/16	06/27/16	0.00	50.00	0.00	0.00	0.00
4540	5916236000457	07/29/16 - 07/29/16	08/29/16	0.00	427.00	0.00	0.00	0.00
615	2016314024098	06/28/16 - 06/28/16	11/14/16	0.00	2,388.00	0.00	0.00	0.00
7693	2217025006089	06/01/16 - 06/01/16	01/30/17	0.00	266.00	0.00	0.00	0.00
33	2217026008774	07/06/16 - 07/06/16	01/30/17	0.00	1,456.00	0.00	0.00	0.00
TOTAL				0.00	9,433.00	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: 08/24/2017
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/15 THROUGH 07/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	383,648.00	ADJUSTMENTS	0.00
COVERED CHARGES	307,162.16	CONTRACTUAL ALLOW	114,021.69
NON-COVERD CHARGES	76,485.84	TOTAL MEDICAID LIAB	193,140.47
		LESS: COB	192,907.16
		LESS: COPAYMENT	233.31
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 154

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

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
 417 W 3RD AVE
 ALBANY,GA 31701-1943

PROVIDER NUMBER
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,865.67	3,572.28	OTHER LAB	670.00	0.00
MED/SURG SUPPLY	31,528.06	910.40	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,456.00	635.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,868.00	15,331.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	13,119.00	FEE SCHEDULE LAB	20,006.00	1,739.00
EKG/ECG	2,604.00	372.00	MRI SERVICES	12,633.00	3,346.00
IV THERAPY	5,616.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	47,948.00	8,277.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	469.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	276.00	187.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,143.00	2,459.00	AMBULANCE	0.00	0.00
GI SERVICES	1,806.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	40,635.00	2,046.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	34,303.00	2,887.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,765.29	2,471.14
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	11,511.00	189.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	7,197.02	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	3,563.00	1,248.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,500.14	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,873.00	10,500.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	92.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,448.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,583.00	0.00			
			TOTAL ANCILLARY	307,162.16	76,485.84
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	307,162.16	76,485.84

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: 08/24/2017
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PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/15 THROUGH 07/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	875,791.77	ADJUSTMENTS	1,905.29
COVERED CHARGES	828,147.98	CONTRACTUAL ALLOW	786,416.74
NON-COVERD CHARGES	47,643.79	TOTAL MEDICAID LIAB	41,731.24
		LESS: COB	0.00
		LESS: COPAYMENT	1,480.74
		REIMBURSEMENT	40,250.50
		TOTAL NUMBER OF CLAIMS	746

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
 417 W 3RD AVE
 ALBANY,GA 31701-1943

PROVIDER NUMBER
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,815.40	1,603.22	OTHER LAB	2,581.00	0.00
MED/SURG SUPPLY	29,641.42	618.77	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	43,093.00	196.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	55,017.00	18,335.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	72,421.00	4,919.00
EKG/ECG	12,276.00	372.00	MRI SERVICES	0.00	1,965.00
IV THERAPY	4,786.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,600.00	1,426.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,469.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	620.00	355.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	531.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	497,624.50	1,690.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,345.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	53,474.42	8,698.30
RADIOLOGY THERAPEUTIC	15,199.00	574.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	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	333.00	300.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	185.00	0.00	IMPL DEV CHARGE PATIENTS	392.74	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,123.00	6,322.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	184.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,387.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	765.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,284.50	0.00			
			TOTAL ANCILLARY	828,147.98	47,643.79
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	828,147.98	47,643.79

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

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/15 THROUGH 07/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,600.67	ADJUSTMENTS	0.00
COVERED CHARGES	11,701.81	CONTRACTUAL ALLOW	3,844.94
NON-COVERD CHARGES	5,898.86	TOTAL MEDICAID LIAB	7,856.87
		LESS: COB	7,839.66
		LESS: COPAYMENT	17.21
		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

Run Date: 08/24/2017
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
 417 W 3RD AVE
 ALBANY,GA 31701-1943

PROVIDER NUMBER
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	300.99	814.20	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	566.78	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	646.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,830.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,473.00	22.00
EKG/ECG	186.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,233.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	296.04	155.66
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	1,077.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	11,701.81	5,898.86
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,701.81	5,898.86

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: 08/24/2017
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/15 THROUGH 07/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,037,498.12	ADJUSTMENTS	354,019.37
COVERED CHARGES	9,292,228.57	CONTRACTUAL ALLOW	8,033,299.05
NON-COVERD CHARGES	745,269.55	TOTAL MEDICAID LIAB	1,258,929.52
		LESS: COB	0.00
		LESS: COPAYMENT	1,493.83
		REIMBURSEMENT	1,257,435.69
		TOTAL NUMBER OF CLAIMS	220

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

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
 417 W 3RD AVE
 ALBANY,GA 31701-1943

PROVIDER NUMBER
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	496,524.96	11,035.24	OTHER LAB	690.00	0.00
MED/SURG SUPPLY	416,201.16	69,783.34	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	39,866.00	2,677.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,496.00	5,060.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	156.00	0.04	FEE SCHEDULE LAB	72,439.00	7,270.00
EKG/ECG	8,686.00	1,860.00	MRI SERVICES	3,346.00	0.00
IV THERAPY	205,203.00	18,428.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,021,207.25	95,278.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,004.00	2,379.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	372,693.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,570.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,798.47	3,244.53	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	160,684.00	990.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,321,546.86	281,462.28
RADIOLOGY THERAPEUTIC	282,644.00	3,518.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	97.04	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	501.02	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	5,724.00	1,870.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	462,132.55	78,110.44
LITHOTRIPSY	96,130.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,727.00	651.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,620.00	9,870.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,559.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	229,934.00	144,218.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	38,216.32	5,396.12			
			TOTAL ANCILLARY	9,292,228.57	745,269.55
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,292,228.57	745,269.55

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

Run Date: 08/24/2017
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	08/01/15	THROUGH	07/31/16
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: 08/24/2017
 Run Time: 03:21:48
 Page: 1

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,038,738.62	ADJUSTMENTS	297,480.47
COVERED CHARGES	5,936,355.62	CONTRACTUAL ALLOW	4,605,287.48
NON-COVERD CHARGES	102,383.00	TOTAL MEDICAID LIAB	1,331,068.14
		LESS: COB	4,258.88
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,326,809.26

TOTAL NUMBER OF ADMISSIONS 167

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	592		0	581,040.00		44,237.00
ROUTINE NURSERY	43		0	31,229.00		101.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	635		0	612,269.00		44,338.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	141		0	357,840.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	141		0	357,840.00		0.00
TOTAL ACCOMODATIONS	776		0	970,109.00		44,338.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,055,074.26	0.00	OTHER LAB	40,565.00	0.00
MED/SURG SUPPLY	82,078.47	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,033,643.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	142,435.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	525,006.00	3,122.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	27,847.42	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	62,764.00	0.00	MRI SERVICES	98,287.00	0.00
IV THERAPY	7,598.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	295,515.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	64,464.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	420,707.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	41,470.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	41,820.00	8,513.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	529,524.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	77,417.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	5,219.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	13,136.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	13,765.00	409.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	84,118.47	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	50,776.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	71,702.00	41,552.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	48,315.00	4,449.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	98,526.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	34,474.00	0.00			
			TOTAL ANCILLARY	4,966,246.62	58,045.00
			TOTAL ACCOMODATIONS	970,109.00	44,338.00
			TOTAL CHARGES	5,936,355.62	102,383.00

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

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

Run Date: 08/24/2017
 Run Time: 03:21:51
 Page: 3

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	119,864.99	ADJUSTMENTS	0.00
COVERED CHARGES	118,597.99	CONTRACTUAL ALLOW	66,544.14
NON-COVERD CHARGES	1,267.00	TOTAL MEDICAID LIAB	52,053.85
		LESS: COB	52,053.85
		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	17		0	16,813.00		1,267.00
ROUTINE NURSERY	2		0	1,440.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	19		0	18,253.00		1,267.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	2		0	5,200.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2		0	5,200.00		0.00
TOTAL ACCOMODATIONS	21		0	23,453.00		1,267.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,144.12	0.00	OTHER LAB	1,484.00	0.00
MED/SURG SUPPLY	1,440.87	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	23,211.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	543.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,010.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	442.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,930.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,209.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,336.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,694.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	7,336.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,380.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	963.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	698.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,324.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	95,144.99	0.00
			TOTAL ACCOMODATIONS	23,453.00	1,267.00
			TOTAL CHARGES	118,597.99	1,267.00

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: 08/24/2017
Run Time: 03:21:51
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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,863,490.93	ADJUSTMENTS	363,956.49
COVERED CHARGES	11,588,780.56	CONTRACTUAL ALLOW	10,160,574.51
NON-COVERD CHARGES	1,274,710.37	TOTAL MEDICAID LIAB	1,428,206.05
		LESS: COB	45,920.01
		LESS: COPAYMENT	3,125.03
		REIMBURSEMENT	1,379,161.01
		ALL OTHER	1,270,101.21
		FEE SCHEDULE-LAB	79,274.77
		INJECTABLE DRUGS	29,785.03
		TOTAL NUMBER OF CLAIMS	2,857

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	241,692.34	5,507.27	OTHER LAB	141,014.00	0.00
MED/SURG SUPPLY	237,812.97	11,830.34	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	605,691.00	8,328.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,196,719.00	261,706.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	676.15	FEE SCHEDULE LAB	1,428,220.00	77,815.00
EKG/ECG	134,368.00	8,840.00	MRI SERVICES	326,142.00	68,948.00
IV THERAPY	28,454.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	816,151.00	221,825.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	49,949.00	0.00	REHAB THERAPY	0.00	2,645.00
RESPIRATORY SERVICES	48,737.00	11,230.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	111,352.00	1,694.00	AMBULANCE	0.00	0.00
GI SERVICES	175,216.00	26,579.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,063,183.00	104,208.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	326,094.00	9,486.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	262,983.78	126,541.55
RADIOLOGY THERAPEUTIC	5,004.00	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	5,173.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	44,916.00	6,271.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	43,063.34	106,632.46
LITHOTRIPSY	78,609.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	339,971.00	65,566.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	41,120.00	26,712.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	213,173.00	65,271.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	285,901.00	39,533.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	64,576.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	278,668.13	11,692.60			
			TOTAL ANCILLARY	11,588,780.56	1,274,710.37
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,588,780.56	1,274,710.37

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

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	189,456.03	ADJUSTMENTS	0.00
COVERED CHARGES	163,514.73	CONTRACTUAL ALLOW	105,972.70
NON-COVERD CHARGES	25,941.30	TOTAL MEDICAID LIAB	57,542.03
		LESS: COB	57,516.68
		LESS: COPAYMENT	25.35
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 40

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,807.89	166.40	OTHER LAB	1,484.00	0.00
MED/SURG SUPPLY	5,435.65	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	393.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,443.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,096.00	16,038.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	23,927.00	1,982.00
EKG/ECG	2,210.00	442.00	MRI SERVICES	3,645.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,017.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,573.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	220.00	369.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,738.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,103.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	47,713.00	2,662.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,027.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,644.19	1,722.90
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,119.00	2,166.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,180.00	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	276.00	0.00			
			TOTAL ANCILLARY	163,514.73	25,941.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	163,514.73	25,941.30

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	560,270.34	ADJUSTMENTS	808.91
COVERED CHARGES	523,538.42	CONTRACTUAL ALLOW	509,931.51
NON-COVERD CHARGES	36,731.92	TOTAL MEDICAID LIAB	13,606.91
		LESS: COB	737.25
		LESS: COPAYMENT	491.36
		REIMBURSEMENT	12,378.30
		TOTAL NUMBER OF CLAIMS	231

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,491.48	0.00	OTHER LAB	1,077.00	0.00
MED/SURG SUPPLY	226.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,901.00	602.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	66,962.00	21,500.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	75,580.00	4,826.00
EKG/ECG	3,536.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	840.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	327,295.00	1,756.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,514.94	2,928.92
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,115.00	5,119.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	523,538.42	36,731.92
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	523,538.42	36,731.92

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

Run Date: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,036.89	ADJUSTMENTS	0.00
COVERED CHARGES	13,281.89	CONTRACTUAL ALLOW	8,949.04
NON-COVERD CHARGES	2,755.00	TOTAL MEDICAID LIAB	4,332.85
		LESS: COB	4,320.85
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	6

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36.89	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	543.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,724.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,010.00	31.00
EKG/ECG	442.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,944.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,306.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	13,281.89	2,755.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,281.89	2,755.00

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	141,472.62	ADJUSTMENTS	0.00
COVERED CHARGES	139,902.42	CONTRACTUAL ALLOW	123,580.62
NON-COVERD CHARGES	1,570.20	TOTAL MEDICAID LIAB	16,321.80
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	16,312.80

TOTAL NUMBER OF CLAIMS 3

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	46,233.53	270.92	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	17,558.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	454.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,168.00	79.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	495.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	37,599.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,613.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,364.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	940.83	302.68
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	13,186.16	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,640.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	650.40	917.60			
			TOTAL ANCILLARY	139,902.42	1,570.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	139,902.42	1,570.20

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: 08/24/2017
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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	07/01/15	THROUGH	06/30/16
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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	82,689,516.58	ADJUSTMENTS	5,970,832.35
COVERED CHARGES	79,560,472.37	CONTRACTUAL ALLOW	62,537,728.10
NON-COVERD CHARGES	3,129,044.21	TOTAL MEDICAID LIAB	17,022,744.27
		LESS: COB	122,557.06
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	16,900,187.21

TOTAL NUMBER OF ADMISSIONS 890

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	5,777	14	5,999,240.00	1,097,431.00
ROUTINE NURSERY	252	0	441,087.00	41,473.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	6,029	14	6,440,327.00	1,138,904.00
SPECIAL CARE SERVICES				
CCU	298	0	944,147.00	0.00
ICU	1,107	0	3,719,228.00	14,640.00
NICU	144	0	454,320.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,549	0	5,117,695.00	14,640.00
TOTAL ACCOMODATIONS	7,578	14	11,558,022.00	1,153,544.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,369,434.85	249,746.46	OTHER LAB	629,852.00	1,749.00
MED/SURG SUPPLY	3,519,498.69	618,695.26	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,757,622.00	288,521.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,926,505.00	4,795.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,186,192.00	38,858.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	680,374.74	9,712.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	560,816.00	1,006.00	MRI SERVICES	848,889.00	5,370.00
IV THERAPY	1,197.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,207,207.00	62,785.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	48,951.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,886,625.00	53,478.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,054,102.00	2,073.00	AMBULANCE	0.00	0.00
GI SERVICES	1,013,979.00	4,007.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,909,741.00	2,125.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	424,478.00	4,419.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	535,441.00	700.00	INJECTABLE DRUGS	2,922.00	0.00
RADIOLOGY THERAPEUTIC	400,706.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	239,270.35	5,374.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	246,187.13	2,718.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	2,264,264.00	66,990.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	26,052.00	47,856.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,985,309.21	153,117.49
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	42,718.00
OTHER IMAGING SERVICE	439,814.00	20,516.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,019,785.00	235,144.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	175,508.00	27,682.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,762,150.00	19,359.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	75,049.00	0.00			
ORGAN ACQUISITION	1,507,165.00	0.00			
TREATMENT/OBSERV. RM	297,363.40	5,986.00			
			TOTAL ANCILLARY	68,002,450.37	1,975,500.21
			TOTAL ACCOMODATIONS	11,558,022.00	1,153,544.00
			TOTAL CHARGES	79,560,472.37	3,129,044.21

PIEDMONT HOSPITAL
 1968 PEACHTREE RD NW
 ATLANTA,GA 30309-1281

PROVIDER NUMBER
 000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015355013244	12/02/15 - 12/14/15	12/28/15	0.00	3,996.00	0.00	0.00	0.00
948	5215362012860	07/16/15 - 08/21/15	02/22/16	0.00	446.00	0.00	0.00	0.00
948	5215362016240	08/26/15 - 09/06/15	02/22/16	0.00	446.00	0.00	0.00	0.00
614	5215362020173	08/30/15 - 09/24/15	02/22/16	0.00	3,996.00	0.00	0.00	0.00
614	5215363005999	10/14/15 - 10/20/15	02/22/16	0.00	3,996.00	0.00	0.00	0.00
614	2016088013271	03/14/16 - 03/23/16	04/04/16	0.00	4,351.00	0.00	0.00	0.00
614	2016133051818	04/18/16 - 05/09/16	05/23/16	0.00	4,351.00	0.00	0.00	0.00
614	2216152001765	03/07/16 - 03/23/16	06/06/16	0.00	8,347.00	0.00	0.00	0.00
614	9816155000070	09/11/15 - 10/10/15	06/13/16	0.00	3,996.00	0.00	0.00	0.00
614	2316209000204	08/13/15 - 08/26/15	08/29/16	0.00	3,996.00	0.00	3,756.79	0.00
614	2316211000054	02/22/16 - 03/01/16	08/15/16	0.00	4,351.00	0.00	0.00	0.00
948	2016258044528	03/01/16 - 03/06/16	09/19/16	0.00	446.00	0.00	0.00	0.00
TOTAL				0.00	42,718.00	0.00	3,756.79	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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	688,208.56	ADJUSTMENTS	0.00
COVERED CHARGES	675,092.56	CONTRACTUAL ALLOW	388,160.39
NON-COVERD CHARGES	13,116.00	TOTAL MEDICAID LIAB	286,932.17
		LESS: COB	286,932.17
		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	47		0	49,632.00		7,058.00
ROUTINE NURSERY	20		0	35,409.00		5,571.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	67		0	85,041.00		12,629.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	7		0	22,560.00		0.00
NICU	8		0	25,240.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	47,800.00		0.00
TOTAL ACCOMODATIONS	82		0	132,841.00		12,629.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	103,236.58	0.00	OTHER LAB	15,025.00	0.00
MED/SURG SUPPLY	17,550.06	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	82,635.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,746.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,502.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,658.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,018.00	0.00	MRI SERVICES	9,443.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	36,866.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	58,720.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	25,254.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,233.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	7,974.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,357.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	31,904.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,760.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	730.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,226.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,157.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	57,820.92	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,355.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,501.00	487.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,408.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,172.00	0.00			
			TOTAL ANCILLARY	542,251.56	487.00
			TOTAL ACCOMODATIONS	132,841.00	12,629.00
			TOTAL CHARGES	675,092.56	13,116.00

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,866,303.57	ADJUSTMENTS	579,346.58
COVERED CHARGES	15,943,570.72	CONTRACTUAL ALLOW	13,606,016.79
NON-COVERD CHARGES	4,922,732.85	TOTAL MEDICAID LIAB	2,337,553.93
		LESS: COB	195,576.70
		LESS: COPAYMENT	5,691.00
		REIMBURSEMENT	2,136,286.23
		ALL OTHER	1,825,629.52
		FEE SCHEDULE-LAB	183,611.75
		INJECTABLE DRUGS	127,044.96
		TOTAL NUMBER OF CLAIMS	4,245

PIEDMONT HOSPITAL
 1968 PEACHTREE RD NW
 ATLANTA,GA 30309-1281

PROVIDER NUMBER
 000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	257,650.96	39,161.54	OTHER LAB	201,780.00	0.00
MED/SURG SUPPLY	318,744.53	343,531.69	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	707,135.00	150,094.00	OTHER THERAPEUTIC SVC	0.00	1,452.00
CT SCAN	1,645,275.00	394,897.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	523.00	9,083.06	FEE SCHEDULE LAB	2,750,144.00	219,573.00
EKG/ECG	261,844.00	15,593.00	MRI SERVICES	455,755.00	68,623.00
IV THERAPY	30,773.00	543.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,475,956.00	424,539.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,448.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	106,935.00	16,607.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	146,169.00	2,768.00	AMBULANCE	0.00	0.00
GI SERVICES	251,379.00	107,487.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,925,286.00	78,324.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	235,064.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	951,610.50	942,905.67
RADIOLOGY THERAPEUTIC	243,631.00	169,472.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	523.00	1,997.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	4,065.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	57,855.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	329,346.00	39,446.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	140,760.75	1,074,388.87
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	17,480.00
OTHER IMAGING SERVICE	367,638.00	91,109.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	168,585.00	13,815.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	272,368.00	91,163.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	991,833.00	533,901.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	348,613.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	349,800.98	12,859.00			
			TOTAL ANCILLARY	15,943,570.72	4,922,732.85
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,943,570.72	4,922,732.85

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

Run Date: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015236012225	08/19/15 - 08/19/15	08/31/15	0.00	3,996.00	0.00	0.00	0.00
614	5916026001148	12/10/15 - 12/10/15	02/01/16	0.00	4,782.00	0.00	0.00	0.00
614	5916026001148	12/10/15 - 12/10/15	02/01/16	0.00	355.00	0.00	0.00	0.00
614	2016140047268	05/16/16 - 05/16/16	05/23/16	0.00	3,996.00	0.00	0.00	0.00
614	5917109000051	01/07/16 - 01/07/16	04/24/17	0.00	3,996.00	0.00	0.00	0.00
614	5917109000051	01/07/16 - 01/07/16	04/24/17	0.00	355.00	0.00	0.00	0.00
TOTAL				0.00	17,480.00	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

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	588,993.46	ADJUSTMENTS	0.00
COVERED CHARGES	365,453.33	CONTRACTUAL ALLOW	191,185.89
NON-COVERD CHARGES	223,540.13	TOTAL MEDICAID LIAB	174,267.44
		LESS: COB	174,124.86
		LESS: COPAYMENT	142.58
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 78

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,353.57	0.00	OTHER LAB	8,954.00	0.00
MED/SURG SUPPLY	8,083.87	1,337.11	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,237.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,478.00	40,542.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	56,785.00	8,039.00
EKG/ECG	3,018.00	0.00	MRI SERVICES	10,172.00	6,067.00
IV THERAPY	1,522.00	436.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	54,578.00	38,500.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,816.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,917.00	2,904.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,351.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,669.00	6,187.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	46,400.00	2,327.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,270.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	25,249.39	57,745.38
RADIOLOGY THERAPEUTIC	35,314.00	18,108.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,045.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,955.00	471.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	959.50	4,463.64
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,415.00	5,800.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,625.00	680.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,294.00	26,888.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,706.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,331.00	0.00			
			TOTAL ANCILLARY	365,453.33	223,540.13
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	365,453.33	223,540.13

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 HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	478,218.65	ADJUSTMENTS	907.51
COVERED CHARGES	430,423.09	CONTRACTUAL ALLOW	418,762.24
NON-COVERD CHARGES	47,795.56	TOTAL MEDICAID LIAB	11,660.85
		LESS: COB	1,423.83
		LESS: COPAYMENT	493.47
		REIMBURSEMENT	9,743.55
		TOTAL NUMBER OF CLAIMS	183

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,032.45	166.40	OTHER LAB	4,475.00	0.00
MED/SURG SUPPLY	2,112.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	30,554.00	494.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	50,252.00	22,583.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	69,459.00	5,243.00
EKG/ECG	8,048.00	0.00	MRI SERVICES	0.00	5,939.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	546.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	236,516.00	3,996.00	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	4,753.64	3,201.16
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	17,675.00	6,173.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	430,423.09	47,795.56
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	430,423.09	47,795.56

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	59,353.64	ADJUSTMENTS	0.00
COVERED CHARGES	56,835.44	CONTRACTUAL ALLOW	48,860.60
NON-COVERD CHARGES	2,518.20	TOTAL MEDICAID LIAB	7,974.84
		LESS: COB	7,897.90
		LESS: COPAYMENT	76.94
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	10

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	206.14	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	308.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,585.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,389.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,015.00	203.00
EKG/ECG	503.00	503.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,901.00	543.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	281.30	83.20
RADIOLOGY THERAPEUTIC	29,675.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	999.00	1,186.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	973.00	0.00			
			TOTAL ANCILLARY	56,835.44	2,518.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	56,835.44	2,518.20

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 HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,381,001.83	ADJUSTMENTS	73,511.13
COVERED CHARGES	1,938,477.48	CONTRACTUAL ALLOW	1,739,859.22
NON-COVERD CHARGES	442,524.35	TOTAL MEDICAID LIAB	198,618.26
		LESS: COB	0.00
		LESS: COPAYMENT	219.00
		REIMBURSEMENT	198,399.26
		TOTAL NUMBER OF CLAIMS	35

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,713.21	998.40	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	63,871.70	141,478.22	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,268.00	82,915.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,182.00	3,482.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	28,217.00	240.00
EKG/ECG	5,030.00	6,036.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,698.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	457,150.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	133,110.00	912.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	29,245.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,735.00	3,857.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	55,636.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	431,176.40	23,442.98
RADIOLOGY THERAPEUTIC	26,454.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	156,223.77	139,325.75
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,291.00	1,954.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	476,934.00	36,168.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,542.40	1,715.00			
			TOTAL ANCILLARY	1,938,477.48	442,524.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,938,477.48	442,524.35

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: 08/24/2017
Run Time: 03:21:39
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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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
 Run Time: 04:01:02
 Page: 1

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

POLK MEDICAL CENTER, INC
 2360 ROCKMART HWY
 CEDARTOWN,GA 30125-6029

PROVIDER NUMBER 000001526A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	116,183.25	ADJUSTMENTS	4,134.03
COVERED CHARGES	116,183.25	CONTRACTUAL ALLOW	94,689.20
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	21,494.05
		LESS: COB	1,579.43
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	19,914.62

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	15		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	15		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	15		0	8,250.00		0.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

POLK MEDICAL CENTER, INC
 2360 ROCKMART HWY
 CEDARTOWN,GA 30125-6029

PROVIDER NUMBER
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,318.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,306.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	22,828.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,326.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,112.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	152.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,194.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	23,684.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,123.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,861.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,480.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,214.25	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	49.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	380.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,200.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,706.00	0.00			
			TOTAL ANCILLARY	107,933.25	0.00
			TOTAL ACCOMODATIONS	8,250.00	0.00
			TOTAL CHARGES	116,183.25	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: 08/24/2017
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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

POLK MEDICAL CENTER, INC
2360 ROCKMART HWY
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
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: 08/24/2017
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POLK MEDICAL CENTER, INC
2360 ROCKMART HWY
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,170,941.39	ADJUSTMENTS	142,582.46
COVERED CHARGES	6,949,739.64	CONTRACTUAL ALLOW	5,604,288.08
NON-COVERD CHARGES	221,201.75	TOTAL MEDICAID LIAB	1,345,451.56
		LESS: COB	724.97
		LESS: COPAYMENT	960.00
		REIMBURSEMENT	1,343,766.59
		ALL OTHER	1,249,565.28
		FEE SCHEDULE-LAB	78,781.14
		INJECTABLE DRUGS	15,420.17
		TOTAL NUMBER OF CLAIMS	2,937

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: 08/24/2017
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POLK MEDICAL CENTER, INC
 2360 ROCKMART HWY
 CEDARTOWN,GA 30125-6029

PROVIDER NUMBER
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	51,214.25	0.00	OTHER LAB	9,703.00	0.00
MED/SURG SUPPLY	264,841.14	6,294.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	6,552.00	EDUCATION & TRAINING	676.00	36.00
RADIOLOGY-DIAGNOSTIC	360,554.00	3,072.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	647,286.00	17,947.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,233,331.00	66,361.00
EKG/ECG	94,802.00	0.00	MRI SERVICES	13,014.00	0.00
IV THERAPY	55,868.00	504.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	61,688.00	18,758.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	58,980.00	18,314.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,032.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,568,785.00	39,006.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,584.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	309,683.50	24,760.75
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	24,647.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	18,685.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	90.00
OTHER IMAGING SERVICE	22,620.00	530.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	851.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	58,929.00	9,622.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	83,965.00	9,355.00			
			TOTAL ANCILLARY	6,949,739.64	221,201.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,949,739.64	221,201.75

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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POLK MEDICAL CENTER, INC
2360 ROCKMART HWY
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
8032	2216207006373	08/27/15 - 08/27/15	08/01/16	0.00	90.00	0.00	0.00	0.00
TOTAL				0.00	90.00	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

POLK MEDICAL CENTER, INC
2360 ROCKMART HWY
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	63,118.50	ADJUSTMENTS	0.00
COVERED CHARGES	51,256.50	CONTRACTUAL ALLOW	26,061.75
NON-COVERD CHARGES	11,862.00	TOTAL MEDICAID LIAB	25,194.75
		LESS: COB	25,194.75
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 18

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

POLK MEDICAL CENTER, INC
 2360 ROCKMART HWY
 CEDARTOWN,GA 30125-6029

PROVIDER NUMBER
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	473.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,547.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,045.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,120.00	10,233.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,008.00	1,522.00
EKG/ECG	919.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	332.00	107.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	29,649.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,859.50	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	304.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	51,256.50	11,862.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	51,256.50	11,862.00

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: 08/24/2017
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POLK MEDICAL CENTER, INC
2360 ROCKMART HWY
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	408,528.07	ADJUSTMENTS	47.00
COVERED CHARGES	407,445.07	CONTRACTUAL ALLOW	392,245.07
NON-COVERD CHARGES	1,083.00	TOTAL MEDICAID LIAB	15,200.00
		LESS: COB	0.00
		LESS: COPAYMENT	429.00
		REIMBURSEMENT	14,771.00
		TOTAL NUMBER OF CLAIMS	304

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

POLK MEDICAL CENTER, INC
 2360 ROCKMART HWY
 CEDARTOWN,GA 30125-6029

PROVIDER NUMBER
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	498.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	12,554.32	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,682.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	24,041.00	228.00
EKG/ECG	872.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	332.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	337,013.00	835.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,403.25	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	49.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	407,445.07	1,083.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	407,445.07	1,083.00

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

POLK MEDICAL CENTER, INC
2360 ROCKMART HWY
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,392.50	ADJUSTMENTS	0.00
COVERED CHARGES	7,392.50	CONTRACTUAL ALLOW	4,428.91
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	2,963.59
		LESS: COB	2,963.59
		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

POLK MEDICAL CENTER, INC
 2360 ROCKMART HWY
 CEDARTOWN,GA 30125-6029

PROVIDER NUMBER
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	177.00	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	1,632.00	0.00
EKG/ECG	275.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,784.00	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	173.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,392.50	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,392.50	0.00

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

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

Run Date: 08/24/2017
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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

POLK MEDICAL CENTER, INC
2360 ROCKMART HWY
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	84,178.50	ADJUSTMENTS	4,862.89
COVERED CHARGES	83,839.75	CONTRACTUAL ALLOW	69,251.08
NON-COVERD CHARGES	338.75	TOTAL MEDICAID LIAB	14,588.67
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	14,585.67
		TOTAL NUMBER OF CLAIMS	3

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

POLK MEDICAL CENTER, INC
 2360 ROCKMART HWY
 CEDARTOWN,GA 30125-6029

PROVIDER NUMBER
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,113.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,182.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	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	0.00	76.00	FEE SCHEDULE LAB	4,785.00	95.00
EKG/ECG	322.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	15,012.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,039.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,205.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,508.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,400.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,034.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,768.50	13.75
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	12,089.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,882.00	154.00			
			TOTAL ANCILLARY	83,839.75	338.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	83,839.75	338.75

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

POLK MEDICAL CENTER, INC
2360 ROCKMART HWY
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER
000001526A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/15	THROUGH	06/30/16
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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	384,983.87	ADJUSTMENTS	54,751.60
COVERED CHARGES	376,156.63	CONTRACTUAL ALLOW	168,346.69
NON-COVERD CHARGES	8,827.24	TOTAL MEDICAID LIAB	207,809.94
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	207,809.94

TOTAL NUMBER OF ADMISSIONS 42

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	137		0	47,950.00		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	137		0	47,950.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	21		0	14,175.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	21		0	14,175.00		0.00
TOTAL ACCOMODATIONS	158		0	62,125.00		0.00

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	91,219.22	0.00	OTHER LAB	2,886.92	0.00
MED/SURG SUPPLY	24,810.61	85.78	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	62,748.59	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,730.16	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	38,852.47	5,693.84	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	417.82	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,244.20	0.00	MRI SERVICES	11,112.76	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	23,714.40	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	28,643.44	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	7,509.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	529.13	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,826.44	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,306.87	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,570.88	1,221.18			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,950.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,785.16	0.00			
			TOTAL ANCILLARY	314,031.63	8,827.24
			TOTAL ACCOMODATIONS	62,125.00	0.00
			TOTAL CHARGES	376,156.63	8,827.24

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

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 10/01/15 THROUGH 09/30/16
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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	792,286.17	ADJUSTMENTS	6,677.71
COVERED CHARGES	650,643.62	CONTRACTUAL ALLOW	405,057.42
NON-COVERD CHARGES	141,642.55	TOTAL MEDICAID LIAB	245,586.20
		LESS: COB	871.65
		LESS: COPAYMENT	546.46
		REIMBURSEMENT	244,168.09
		ALL OTHER	221,871.21
		FEE SCHEDULE-LAB	20,462.64
		INJECTABLE DRUGS	1,834.24

TOTAL NUMBER OF CLAIMS 816

SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

PUTNAM GENERAL HOSPITAL
 101 LAKE OCONEE PARKWAY
 EATONTON,GA 31024-6054

PROVIDER NUMBER
 000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,270.50	15,593.00	OTHER LAB	45,484.37	0.00
MED/SURG SUPPLY	22,383.84	10,060.88	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	561.85	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	35,169.09	1,276.69	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	89,728.34	68,054.21	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	284.12	111.41	FEE SCHEDULE LAB	112,151.97	7,538.23
EKG/ECG	9,644.78	596.00	MRI SERVICES	14,035.07	1,653.74
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,019.25	1,632.09	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,385.59	1,167.06	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,783.72	1,281.20	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	210,648.00	722.27	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,880.49	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20,654.22	8,758.56
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	3,986.33	536.58	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,147.99	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	754.14	203.53			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,950.00	20,528.40			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,690.00	1,300.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,591.81	66.85			
			TOTAL ANCILLARY	650,643.62	141,642.55
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	650,643.62	141,642.55

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

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

Run Date: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,245.14	ADJUSTMENTS	0.00
COVERED CHARGES	4,028.65	CONTRACTUAL ALLOW	1,317.55
NON-COVERD CHARGES	216.49	TOTAL MEDICAID LIAB	2,711.10
		LESS: COB	2,711.10
		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

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	38.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	221.06	139.21	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	414.57	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	829.13	34.28
EKG/ECG	217.23	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,322.66	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	24.00	5.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,028.65	216.49
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,028.65	216.49

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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	66,007.64	ADJUSTMENTS	279.35
COVERED CHARGES	53,075.95	CONTRACTUAL ALLOW	48,680.43
NON-COVERD CHARGES	12,931.69	TOTAL MEDICAID LIAB	4,395.52
		LESS: COB	0.00
		LESS: COPAYMENT	166.31
		REIMBURSEMENT	4,229.21
		TOTAL NUMBER OF CLAIMS	96

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,113.00	775.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	569.08	35.56	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,947.66	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,971.30	10,990.52	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,349.86	286.76
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	33,533.56	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,252.99	521.99
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	338.50	321.36			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	53,075.95	12,931.69
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	53,075.95	12,931.69

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: 08/24/2017
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Page: 10

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 10/01/15 THROUGH 09/30/16
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: 08/24/2017
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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	10/01/15	THROUGH	09/30/16
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: 08/24/2017
Run Time: 04:01:30
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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	10/01/15	THROUGH	09/30/16
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: 08/24/2017
 Run Time: 04:15:11
 Page: 1

TAYLOR REGIONAL HOSPITAL
 222 PERRY HWY
 HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER 000001548A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,274,017.43	ADJUSTMENTS	292,311.93
COVERED CHARGES	1,258,134.93	CONTRACTUAL ALLOW	378,845.94
NON-COVERD CHARGES	15,882.50	TOTAL MEDICAID LIAB	879,288.99
		LESS: COB	7,642.15
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	871,646.84

TOTAL NUMBER OF ADMISSIONS 123

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	267		0	138,373.00		10,130.00
ROUTINE NURSERY	26		0	13,520.00		260.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	293		0	151,893.00		10,390.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	89		0	113,297.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	89		0	113,297.00		0.00
TOTAL ACCOMODATIONS	382		0	265,190.00		10,390.00

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 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	171,425.20	0.00	OTHER LAB	5,065.50	0.00
MED/SURG SUPPLY	77,659.22	191.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	163,724.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,546.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	45,651.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	13,918.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,634.00	0.00	MRI SERVICES	30,237.00	0.00
IV THERAPY	60.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	106,254.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,293.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	38,660.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	31,572.00	0.00	AMBULANCE	0.00	1,168.50
GI SERVICES	3,010.50	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	63,847.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,828.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,008.30	0.00	INJECTABLE DRUGS	101,731.42	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,020.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	205.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	15,259.39	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,007.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	19,035.00	2,328.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	8,299.50	1,805.00			
AUDIOLOGY	2,632.50	0.00			
CARDIOLOGY	22,703.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	16,656.90	0.00			
			TOTAL ANCILLARY	992,944.93	5,492.50
			TOTAL ACCOMODATIONS	265,190.00	10,390.00
			TOTAL CHARGES	1,258,134.93	15,882.50

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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/15	THROUGH	03/31/16
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: 08/24/2017
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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 04/01/15 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,958,607.54	ADJUSTMENTS	31,554.19
COVERED CHARGES	1,860,516.28	CONTRACTUAL ALLOW	1,433,628.56
NON-COVERD CHARGES	98,091.26	TOTAL MEDICAID LIAB	426,887.72
		LESS: COB	2,187.96
		LESS: COPAYMENT	2,061.00
		REIMBURSEMENT	422,638.76
		ALL OTHER	347,589.61
		FEE SCHEDULE-LAB	68,101.61
		INJECTABLE DRUGS	6,947.54
		TOTAL NUMBER OF CLAIMS	1,994

TAYLOR REGIONAL HOSPITAL
 222 PERRY HWY
 HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
 000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63,665.70	9,944.50	OTHER LAB	36,768.00	0.00
MED/SURG SUPPLY	72,221.84	662.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	544.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	101,892.50	916.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	180,654.50	8,392.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	726.00	1,863.00	FEE SCHEDULE LAB	406,801.75	12,856.00
EKG/ECG	20,815.00	382.00	MRI SERVICES	79,815.50	0.00
IV THERAPY	8,037.00	220.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	190,081.50	13,251.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,908.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,028.00	23.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	80,292.00	0.00	AMBULANCE	0.00	651.00
GI SERVICES	73,672.50	5,801.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	273,646.49	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	29,370.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	42,940.50	12,302.48
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	280.00	140.03	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	333.00	555.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	3,050.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	69,278.00	4,968.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,825.00	2,721.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	36,201.50	14,083.00			
AUDIOLOGY	0.00	292.50			
CARDIOLOGY	51,665.00	2,986.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	34,597.00	1,485.00			
			TOTAL ANCILLARY	1,860,516.28	98,091.26
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,860,516.28	98,091.26

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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/15 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,089.25	ADJUSTMENTS	0.00
COVERED CHARGES	19,681.75	CONTRACTUAL ALLOW	10,548.93
NON-COVERD CHARGES	9,407.50	TOTAL MEDICAID LIAB	9,132.82
		LESS: COB	9,120.82
		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

TAYLOR REGIONAL HOSPITAL
 222 PERRY HWY
 HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
 000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	480.50	115.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	278.75	55.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	786.00	154.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,152.00	3,291.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,642.00	779.00
EKG/ECG	264.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,323.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,868.00	354.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	50.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,897.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,090.00	3,300.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	900.00	1,309.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	19,681.75	9,407.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	19,681.75	9,407.50

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: 08/24/2017
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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 04/01/15 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	94,817.85	ADJUSTMENTS	148.16
COVERED CHARGES	91,928.85	CONTRACTUAL ALLOW	83,541.88
NON-COVERD CHARGES	2,889.00	TOTAL MEDICAID LIAB	8,386.97
		LESS: COB	0.00
		LESS: COPAYMENT	346.48
		REIMBURSEMENT	8,040.49
		TOTAL NUMBER OF CLAIMS	159

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 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,061.60	300.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	986.75	54.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,066.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,405.50	1,645.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	14,601.00	223.00
EKG/ECG	396.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	48.50	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	53,652.50	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	2,760.00	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	1,219.50	406.50			
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	731.50	0.00			
			TOTAL ANCILLARY	91,928.85	2,889.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	91,928.85	2,889.00

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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/15 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	462.00	ADJUSTMENTS	0.00
COVERED CHARGES	462.00	CONTRACTUAL ALLOW	63.30
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	398.70
		LESS: COB	392.70
		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

Run Date: 08/24/2017
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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 04/01/15 THROUGH 03/31/16
ADMISSION DATES 00/00/00 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	462.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	462.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	462.00	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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/15	THROUGH	03/31/16
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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/15	THROUGH	03/31/16
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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	383,982.05	ADJUSTMENTS	38,675.69
COVERED CHARGES	352,412.05	CONTRACTUAL ALLOW	215,536.96
NON-COVERD CHARGES	31,570.00	TOTAL MEDICAID LIAB	136,875.09
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	136,875.09

TOTAL NUMBER OF ADMISSIONS 27

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	46		29	27,000.00		28,925.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	46		29	27,000.00		28,925.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	46		29	27,000.00		28,925.00

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	40,526.52	0.00	OTHER LAB	3,898.00	0.00
MED/SURG SUPPLY	28,892.27	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	77,124.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,316.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	31,581.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,933.32	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,088.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	31,896.98	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	2,500.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	17,448.00	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	16,976.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	46,697.52	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,049.84	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	494.00	0.00			
BLOOD	5,466.00	145.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,150.00	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	5,874.60	0.00			
			TOTAL ANCILLARY	325,412.05	2,645.00
			TOTAL ACCOMODATIONS	27,000.00	28,925.00
			TOTAL CHARGES	352,412.05	31,570.00

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 01/01/16 THROUGH 12/31/16
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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	632,635.31	ADJUSTMENTS	82,371.02
COVERED CHARGES	525,889.36	CONTRACTUAL ALLOW	351,236.68
NON-COVERD CHARGES	106,745.95	TOTAL MEDICAID LIAB	174,652.68
		LESS: COB	0.00
		LESS: COPAYMENT	654.81
		REIMBURSEMENT	173,997.87
		ALL OTHER	158,140.67
		FEE SCHEDULE-LAB	14,032.43
		INJECTABLE DRUGS	1,824.77

TOTAL NUMBER OF CLAIMS 575

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,561.96	2,366.84	OTHER LAB	5,261.00	0.00
MED/SURG SUPPLY	28,782.63	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	32,032.00	979.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	67,025.00	62,597.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	132,107.00	14,974.00
EKG/ECG	5,766.00	1,898.00	MRI SERVICES	0.00	0.00
IV THERAPY	43,238.89	5,305.13	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,500.00	2,500.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,297.00	1,575.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	114,192.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,736.38	5,859.98
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,662.00
OTHER IMAGING SERVICE	7,128.00	1,430.00			
BLOOD	1,662.00	580.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,460.00	2,460.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	33,139.50	2,456.00			
			TOTAL ANCILLARY	525,889.36	106,642.95
			TOTAL ACCOMODATIONS	0.00	103.00
			TOTAL CHARGES	525,889.36	106,745.95

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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5916081000190	01/14/16 - 01/14/16	03/28/16	0.00	831.00	0.00	0.00	0.00
-1	5916193000122	02/23/16 - 02/23/16	07/18/16	0.00	831.00	0.00	0.00	0.00
TOTAL				0.00	1,662.00	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

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,713.02	ADJUSTMENTS	0.00
COVERED CHARGES	2,574.94	CONTRACTUAL ALLOW	1,639.83
NON-COVERD CHARGES	138.08	TOTAL MEDICAID LIAB	935.11
		LESS: COB	927.35
		LESS: COPAYMENT	7.76
		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

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	13.36	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	59.72	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	391.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,576.00	60.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	70.32	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	58.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	428.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	49.90	6.72
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,574.94	138.08
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,574.94	138.08

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

Run Date: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,870.42	ADJUSTMENTS	241.00
COVERED CHARGES	11,638.75	CONTRACTUAL ALLOW	10,888.75
NON-COVERD CHARGES	1,231.67	TOTAL MEDICAID LIAB	750.00
		LESS: COB	0.00
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	729.00
		TOTAL NUMBER OF CLAIMS	15

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

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

Run Date: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	539.60	14.36	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	597.04	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	127.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,027.00	90.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,331.15	191.31	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,338.00	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	210.96	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	468.00	936.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	11,638.75	1,231.67
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,638.75	1,231.67

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: 08/24/2017
Run Time: 03:51:31
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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	01/01/16	THROUGH	12/31/16
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

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,175.30	ADJUSTMENTS	4,669.86
COVERED CHARGES	16,713.01	CONTRACTUAL ALLOW	12,037.15
NON-COVERD CHARGES	6,462.29	TOTAL MEDICAID LIAB	4,675.86
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	4,669.86

TOTAL NUMBER OF CLAIMS 1

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	402.44	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,721.71	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	278.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,433.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,031.00	165.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,549.94	156.24	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	5,620.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	1,000.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,688.72	521.05
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,608.20	0.00			
			TOTAL ANCILLARY	16,713.01	6,462.29
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,713.01	6,462.29

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: 08/24/2017
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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	01/01/16	THROUGH	12/31/16
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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	42,331,910.83	ADJUSTMENTS	1,683,034.93
COVERED CHARGES	41,792,958.58	CONTRACTUAL ALLOW	34,763,734.08
NON-COVERD CHARGES	538,952.25	TOTAL MEDICAID LIAB	7,029,224.50
		LESS: COB	50,222.81
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,979,001.69

TOTAL NUMBER OF ADMISSIONS 570

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,943		0	2,100,792.50		306,277.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,943		0	2,100,792.50		306,277.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	723		0	1,599,221.00		13,482.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	723		0	1,599,221.00		13,482.00
TOTAL ACCOMODATIONS	3,666		0	3,700,013.50		319,759.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,143,744.09	0.00	OTHER LAB	268,721.00	0.00
MED/SURG SUPPLY	2,682,032.00	9,078.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,360,966.75	3,335.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,056,698.00	1,548.00	OTHER THERAPEUTIC SVC	0.00	6,883.00
CT SCAN	2,506,440.00	33,960.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	855,435.03	1,823.25	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	417,517.00	0.00	MRI SERVICES	432,999.00	0.00
IV THERAPY	34,043.00	708.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,409,662.00	3,739.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,341,743.00	3,633.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	588,310.00	0.00	AMBULANCE	0.00	5,030.50
GI SERVICES	80,041.00	3,182.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,257,134.50	1,615.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	447,984.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,534.50
LABORATORY PATHOLOGIC	226,649.50	0.00	INJECTABLE DRUGS	3,838,065.04	2,323.25
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	734,751.20	2,242.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	318,858.22	1,153.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	27,386.00	3,210.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,644.50	173.00	TRAUMA RESPONSE	0.00	59,400.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,147,601.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	185,797.00	10,723.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	172,629.00	63,899.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	472,181.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,957,949.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	28,338.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	96,625.25	0.00			
			TOTAL ANCILLARY	38,092,945.08	219,193.25
			TOTAL ACCOMODATIONS	3,700,013.50	319,759.00
			TOTAL CHARGES	41,792,958.58	538,952.25

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	124,944.61	ADJUSTMENTS	0.00
COVERED CHARGES	124,607.61	CONTRACTUAL ALLOW	99,780.94
NON-COVERD CHARGES	337.00	TOTAL MEDICAID LIAB	24,826.67
		LESS: COB	24,826.67
		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	4,998.00		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	7		0	4,998.00		337.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	4,998.00		337.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,821.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,308.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,923.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,456.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	967.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	991.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	26,683.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	606.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,291.00	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	5,582.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	11,335.00	0.00	INJECTABLE DRUGS	4,546.86	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	43,099.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	119,609.61	0.00
			TOTAL ACCOMODATIONS	4,998.00	337.00
			TOTAL CHARGES	124,607.61	337.00

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: 08/24/2017
Run Time: 04:01:42
Page: 5

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,163,002.04	ADJUSTMENTS	63,964.96
COVERED CHARGES	18,774,085.43	CONTRACTUAL ALLOW	16,750,023.72
NON-COVERD CHARGES	1,388,916.61	TOTAL MEDICAID LIAB	2,024,061.71
		LESS: COB	365.91
		LESS: COPAYMENT	5,452.44
		REIMBURSEMENT	2,018,243.36
		ALL OTHER	1,884,114.00
		FEE SCHEDULE-LAB	119,185.12
		INJECTABLE DRUGS	14,944.24

TOTAL NUMBER OF CLAIMS 3,721

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	123,124.32	187.75	OTHER LAB	81,443.00	0.00
MED/SURG SUPPLY	628,580.75	33,934.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,073,628.00	3,549.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,995,680.00	349,735.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	66,103.50	68,065.75	FEE SCHEDULE LAB	4,229,905.78	49,887.50
EKG/ECG	408,048.00	510.00	MRI SERVICES	175,238.00	38,299.00
IV THERAPY	814,971.75	2,717.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,151,088.69	219,642.31	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	40,485.50	8,570.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	351,785.00	3,180.00	AMBULANCE	0.00	0.00
GI SERVICES	107,294.00	16,991.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,402,966.25	8,580.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	322,008.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	164,294.89	46,860.23
RADIOLOGY THERAPEUTIC	24,910.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	70,978.25	32,810.25	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	8,774.00	7,039.03	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	10,743.00	3,675.00	TRAUMA RESPONSE	0.00	9,900.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	254,600.00	10,025.00
LITHOTRIPSY	321,085.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	138,845.75	24,013.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,877.00	2,653.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	358,274.00	156,044.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	983,869.00	274,176.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,368.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	453,116.00	17,872.54			
			TOTAL ANCILLARY	18,774,085.43	1,388,916.61
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,774,085.43	1,388,916.61

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	294,997.80	ADJUSTMENTS	0.00
COVERED CHARGES	194,463.80	CONTRACTUAL ALLOW	146,377.20
NON-COVERD CHARGES	100,534.00	TOTAL MEDICAID LIAB	48,086.60
		LESS: COB	47,940.87
		LESS: COPAYMENT	145.73
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 43

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,174.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	11,093.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,569.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,186.00	12,365.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	11,438.00	422.00	FEE SCHEDULE LAB	62,336.00	1,118.00
EKG/ECG	3,541.00	0.00	MRI SERVICES	0.00	2,649.00
IV THERAPY	8,105.00	248.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,913.00	28,004.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	307.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,248.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,547.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	34,394.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,525.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,832.05	818.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,390.00	4,410.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,672.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	8,942.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	450.00	40,011.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,289.75	0.00			
			TOTAL ANCILLARY	194,463.80	100,534.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	194,463.80	100,534.00

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,130,596.88	ADJUSTMENTS	105.88
COVERED CHARGES	1,082,272.88	CONTRACTUAL ALLOW	1,056,037.02
NON-COVERD CHARGES	48,324.00	TOTAL MEDICAID LIAB	26,235.86
		LESS: COB	0.00
		LESS: COPAYMENT	1,131.00
		REIMBURSEMENT	25,104.86
		TOTAL NUMBER OF CLAIMS	469

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,659.50	0.00	OTHER LAB	3,214.00	0.00
MED/SURG SUPPLY	3,798.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	70,990.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	206,706.00	33,522.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	236,012.50	9,217.50
EKG/ECG	13,306.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	46,956.50	1,553.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,005.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,556.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	479,880.00	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	3,530.38	1,692.50
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	77.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,597.00	2,262.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,674.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,388.00	0.00			
			TOTAL ANCILLARY	1,082,272.88	48,324.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,082,272.88	48,324.00

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

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

Run Date: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,487.75	ADJUSTMENTS	0.00
COVERED CHARGES	26,016.75	CONTRACTUAL ALLOW	22,836.15
NON-COVERD CHARGES	471.00	TOTAL MEDICAID LIAB	3,180.60
		LESS: COB	3,168.60
		LESS: COPAYMENT	12.00
		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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	69.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	10,832.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,370.25	289.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,321.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,327.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	97.50	182.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	26,016.75	471.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	26,016.75	471.00

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

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

Run Date: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,134,470.50	ADJUSTMENTS	15,992.94
COVERED CHARGES	5,895,135.33	CONTRACTUAL ALLOW	5,616,384.43
NON-COVERD CHARGES	239,335.17	TOTAL MEDICAID LIAB	278,750.90
		LESS: COB	0.00
		LESS: COPAYMENT	258.79
		REIMBURSEMENT	278,492.11

TOTAL NUMBER OF CLAIMS 52

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

REDMOND REGIONAL MEDICAL CENTER PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
 501 REDMOND RD 000001581A SERVICE DATES 07/01/15 THROUGH 06/30/16
 ROME,GA 30165-1415 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,142.75	175.00	OTHER LAB	4,486.00	0.00
MED/SURG SUPPLY	396,907.00	3,075.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	36,062.00	4,014.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,092.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	422.00	FEE SCHEDULE LAB	70,701.25	1,806.00
EKG/ECG	22,208.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,725.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,977,044.00	47,316.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,863.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	27,656.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,218.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	27,718.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	86,949.75	5,499.50
RADIOLOGY THERAPEUTIC	5,253.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	78.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,579,290.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	14,480.00	4,554.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	548,121.00	156,899.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	37,217.33	15,496.67			
			TOTAL ANCILLARY	5,895,135.33	239,335.17
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,895,135.33	239,335.17

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	177,605.25	ADJUSTMENTS	0.00
COVERED CHARGES	177,068.75	CONTRACTUAL ALLOW	128,459.18
NON-COVERD CHARGES	536.50	TOTAL MEDICAID LIAB	48,609.57
		LESS: COB	48,603.57
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	552.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,306.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	639.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	537.00	0.00
EKG/ECG	510.00	510.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	88,655.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	515.50	26.50
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	79,010.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,344.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	177,068.75	536.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	177,068.75	536.50

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

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

Run Date: 08/24/2017
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 Page: 1

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

ROCKDALE MEDICAL CENTER
 1412 MILSTEAD AVENUE, NE
 CONYERS,GA 30012-3877

PROVIDER NUMBER 000001603A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,741,712.08	ADJUSTMENTS	949,009.48
COVERED CHARGES	21,796,633.87	CONTRACTUAL ALLOW	16,582,983.19
NON-COVERD CHARGES	945,078.21	TOTAL MEDICAID LIAB	5,213,650.68
		LESS: COB	22,644.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,191,006.68

TOTAL NUMBER OF ADMISSIONS 731

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,263		0	1,438,531.00		505,714.00
ROUTINE NURSERY	544		0	1,334,060.00		67,804.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,807		0	2,772,591.00		573,518.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	288		0	479,062.00		0.00
NICU	84		0	530,151.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	372		0	1,009,213.00		0.00
TOTAL ACCOMODATIONS	3,179		0	3,781,804.00		573,518.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

ROCKDALE MEDICAL CENTER
 1412 MILSTEAD AVENUE, NE
 CONYERS,GA 30012-3877

PROVIDER NUMBER
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,082,654.08	0.00	OTHER LAB	132,205.00	0.00
MED/SURG SUPPLY	1,233,859.65	119.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,603,252.46	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	350,646.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,184,473.00	4,695.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	72,844.20	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	216,513.00	0.00	MRI SERVICES	251,890.00	0.00
IV THERAPY	340,049.00	0.00	PROFESSIONAL FEES	0.00	604.00
OPERATING ROOM	883,207.10	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	738,304.00	36,032.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	781,832.10	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	303,418.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	155,985.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	857,393.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	260,316.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	63,429.21
LABORATORY PATHOLOGIC	112,775.15	0.00	INJECTABLE DRUGS	1,381,357.13	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	23,953.12	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	16,899.03	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	274,120.00	30,072.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	23,317.00	1,869.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	395,361.85	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	36,501.00
OTHER IMAGING SERVICE	222,201.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	430,678.00	174,767.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	106,161.00	23,472.00			
AUDIOLOGY	20,657.00	0.00			
CARDIOLOGY	1,433,768.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	25,623.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	99,117.00	0.00			
			TOTAL ANCILLARY	18,014,829.87	371,560.21
			TOTAL ACCOMODATIONS	3,781,804.00	573,518.00
			TOTAL CHARGES	21,796,633.87	945,078.21

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

ROCKDALE MEDICAL CENTER
 1412 MILSTEAD AVENUE, NE
 CONYERS,GA 30012-3877

PROVIDER NUMBER
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5215363005711	10/14/15 - 10/19/15	02/22/16	0.00	2,468.00	0.00	0.00	0.00
615	2016025033001	01/13/16 - 01/18/16	02/01/16	0.00	5,242.00	0.00	0.00	0.00
615	2016083003835	03/12/16 - 03/13/16	03/28/16	0.00	2,650.00	0.00	0.00	0.00
615	2016103021209	03/15/16 - 03/23/16	04/18/16	0.00	5,242.00	0.00	0.00	0.00
615	2016121001641	04/07/16 - 04/08/16	05/09/16	0.00	2,650.00	0.00	0.00	0.00
615	2016131002272	04/25/16 - 05/04/16	05/23/16	0.00	2,650.00	0.00	0.00	0.00
615	2016132005303	04/05/16 - 04/17/16	05/23/16	0.00	2,592.00	0.00	0.00	0.00
615	2316181000219	11/02/15 - 11/05/15	07/04/16	0.00	2,523.00	0.00	13.54	0.00
615	5916203000008	06/25/16 - 07/01/16	07/25/16	0.00	5,242.00	0.00	0.00	0.00
615	2016218003807	07/25/16 - 07/26/16	08/08/16	0.00	5,242.00	0.00	0.00	0.00
TOTAL				0.00	36,501.00	0.00	13.54	0.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

ROCKDALE MEDICAL CENTER
 1412 MILSTEAD AVENUE, NE
 CONYERS,GA 30012-3877

PROVIDER NUMBER 000001603A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	275,334.87	ADJUSTMENTS	0.00
COVERED CHARGES	265,864.87	CONTRACTUAL ALLOW	177,885.78
NON-COVERD CHARGES	9,470.00	TOTAL MEDICAID LIAB	87,979.09
		LESS: COB	87,979.09
		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	30		0	18,966.00		1,305.00
ROUTINE NURSERY	7		0	22,620.00		803.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	37		0	41,586.00		2,108.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	11		0	69,861.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	69,861.00		0.00
TOTAL ACCOMODATIONS	48		0	111,447.00		2,108.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

ROCKDALE MEDICAL CENTER
 1412 MILSTEAD AVENUE, NE
 CONYERS,GA 30012-3877

PROVIDER NUMBER
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,900.53	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,105.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	58,251.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,689.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,210.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,594.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,967.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,826.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,949.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,070.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,170.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,518.00	0.00	INJECTABLE DRUGS	25,349.34	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	537.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	199.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,204.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,827.00	7,077.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,790.00	285.00			
AUDIOLOGY	378.00	0.00			
CARDIOLOGY	1,526.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	358.00	0.00			
			TOTAL ANCILLARY	154,417.87	7,362.00
			TOTAL ACCOMODATIONS	111,447.00	2,108.00
			TOTAL CHARGES	265,864.87	9,470.00

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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ROCKDALE MEDICAL CENTER
1412 MILSTEAD AVENUE, NE
CONYERS,GA 30012-3877

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,327,617.97	ADJUSTMENTS	369,642.50
COVERED CHARGES	16,630,402.59	CONTRACTUAL ALLOW	14,730,761.80
NON-COVERD CHARGES	2,697,215.38	TOTAL MEDICAID LIAB	1,899,640.79
		LESS: COB	4,775.44
		LESS: COPAYMENT	3,803.08
		REIMBURSEMENT	1,891,062.27
		ALL OTHER	1,669,148.41
		FEE SCHEDULE-LAB	190,909.75
		INJECTABLE DRUGS	31,004.11
		TOTAL NUMBER OF CLAIMS	4,964

ROCKDALE MEDICAL CENTER
 1412 MILSTEAD AVENUE, NE
 CONYERS,GA 30012-3877

PROVIDER NUMBER
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,989.59	8,275.53	OTHER LAB	229,166.00	3,478.00
MED/SURG SUPPLY	443,398.62	412,484.28	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	11,686.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	586,743.00	16,342.00	OTHER THERAPEUTIC SVC	0.00	350.00
CT SCAN	2,428,121.00	237,166.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	51,344.40	7,026.00	FEE SCHEDULE LAB	3,964,127.70	270,580.00
EKG/ECG	363,874.00	6,861.00	MRI SERVICES	296,962.00	32,083.00
IV THERAPY	1,004,616.00	2,150.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	729,068.10	204,255.14	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	37,621.24	31,580.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	292,329.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	240,786.36	47,216.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,420,837.00	1,775.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	252,017.00	0.00	DRUG-SPECIFIC/HOME IV	7,910.88	2,424.77
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	155,591.45	33,942.44
RADIOLOGY THERAPEUTIC	6,083.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,575.00	1,437.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,242.00	1,265.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	25,740.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	34,402.00	3,668.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	254,039.75	161,529.72
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	23,240.00
OTHER IMAGING SERVICE	662,863.00	97,009.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	45,391.00	22,477.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	164,284.00	99,931.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	300,408.50	927,842.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,864.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	622,747.00	3,401.00			
			TOTAL ANCILLARY	16,630,402.59	2,697,215.38
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,630,402.59	2,697,215.38

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: 08/24/2017
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ROCKDALE MEDICAL CENTER
 1412 MILSTEAD AVENUE, NE
 CONYERS,GA 30012-3877

PROVIDER NUMBER
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2216008011312	11/01/15 - 11/01/15	01/11/16	0.00	2,523.00	0.00	0.00	0.00
615	2216008011312	11/01/15 - 11/01/15	01/11/16	0.00	2,468.00	0.00	0.00	0.00
615	2016071021088	11/02/15 - 11/02/15	03/14/16	0.00	2,523.00	0.00	0.00	0.00
615	2016161099085	05/20/16 - 05/20/16	06/13/16	0.00	2,650.00	0.00	0.00	0.00
615	2016161099085	05/20/16 - 05/20/16	06/13/16	0.00	2,592.00	0.00	0.00	0.00
615	5016214958049	06/16/16 - 06/16/16	08/08/16	0.00	2,650.00	0.00	0.00	0.00
615	2016274128935	09/07/16 - 09/07/16	10/10/16	0.00	2,592.00	0.00	0.00	0.00
615	5916327000059	08/15/16 - 08/15/16	11/28/16	0.00	2,650.00	0.00	0.00	0.00
615	5916327000059	08/15/16 - 08/15/16	11/28/16	0.00	2,592.00	0.00	0.00	0.00
TOTAL				0.00	23,240.00	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: 08/24/2017
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ROCKDALE MEDICAL CENTER
1412 MILSTEAD AVENUE, NE
CONYERS,GA 30012-3877

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	360,768.88	ADJUSTMENTS	0.00
COVERED CHARGES	256,146.47	CONTRACTUAL ALLOW	175,637.67
NON-COVERD CHARGES	104,622.41	TOTAL MEDICAID LIAB	80,508.80
		LESS: COB	80,469.80
		LESS: COPAYMENT	39.00
		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

ROCKDALE MEDICAL CENTER
 1412 MILSTEAD AVENUE, NE
 CONYERS,GA 30012-3877

PROVIDER NUMBER
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,516.76	697.03	OTHER LAB	2,470.00	0.00
MED/SURG SUPPLY	3,293.25	9,666.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,952.00	389.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,378.00	20,084.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,709.00	0.00	FEE SCHEDULE LAB	77,279.00	4,650.80
EKG/ECG	5,409.00	0.00	MRI SERVICES	0.00	3,120.00
IV THERAPY	16,402.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	25,132.00	1,121.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	273.00	964.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,380.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	54,354.00	730.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,526.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,830.46	706.58
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	516.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	687.00	102.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	10,754.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,502.00	8,790.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,016.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	2,325.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	11,977.00	50,761.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,306.00	0.00			
			TOTAL ANCILLARY	256,146.47	104,622.41
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	256,146.47	104,622.41

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: 08/24/2017
Run Time: 04:02:35
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ROCKDALE MEDICAL CENTER
1412 MILSTEAD AVENUE, NE
CONYERS,GA 30012-3877

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	588,738.17	ADJUSTMENTS	1,832.96
COVERED CHARGES	554,144.76	CONTRACTUAL ALLOW	528,692.06
NON-COVERD CHARGES	34,593.41	TOTAL MEDICAID LIAB	25,452.70
		LESS: COB	35.09
		LESS: COPAYMENT	705.68
		REIMBURSEMENT	24,711.93
		TOTAL NUMBER OF CLAIMS	455

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

ROCKDALE MEDICAL CENTER
 1412 MILSTEAD AVENUE, NE
 CONYERS,GA 30012-3877

PROVIDER NUMBER
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	707.26	0.00	OTHER LAB	7,006.00	0.00
MED/SURG SUPPLY	1,556.00	334.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,582.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,065.00	370.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,081.00	5,835.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	170,516.60	13,616.20
EKG/ECG	8,586.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	24,058.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,930.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	575.00	308.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	290,315.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	494.43	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,422.47	338.21
RADIOLOGY THERAPEUTIC	304.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,247.00	8,696.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,954.00	1,189.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	2,325.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,327.00	0.00			
			TOTAL ANCILLARY	554,144.76	34,593.41
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	554,144.76	34,593.41

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

ROCKDALE MEDICAL CENTER
1412 MILSTEAD AVENUE, NE
CONYERS,GA 30012-3877

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,628.31	ADJUSTMENTS	0.00
COVERED CHARGES	13,823.31	CONTRACTUAL ALLOW	8,446.76
NON-COVERD CHARGES	805.00	TOTAL MEDICAID LIAB	5,376.55
		LESS: COB	5,373.55
		LESS: COPAYMENT	3.00
		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: 08/24/2017
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ROCKDALE MEDICAL CENTER
 1412 MILSTEAD AVENUE, NE
 CONYERS,GA 30012-3877

PROVIDER NUMBER
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	87.31	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	838.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,622.00	221.00
EKG/ECG	708.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,568.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	584.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	13,823.31	805.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,823.31	805.00

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

ROCKDALE MEDICAL CENTER
1412 MILSTEAD AVENUE, NE
CONYERS,GA 30012-3877

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	745,281.34	ADJUSTMENTS	27,702.15
COVERED CHARGES	532,303.82	CONTRACTUAL ALLOW	471,306.29
NON-COVERD CHARGES	212,977.52	TOTAL MEDICAID LIAB	60,997.53
		LESS: COB	0.00
		LESS: COPAYMENT	39.00
		REIMBURSEMENT	60,958.53

TOTAL NUMBER OF CLAIMS 11

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

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

Run Date: 08/24/2017
 Run Time: 04:02:38
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SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROCKDALE MEDICAL CENTER
 1412 MILSTEAD AVENUE, NE
 CONYERS,GA 30012-3877

PROVIDER NUMBER
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	402.47	803.13	OTHER LAB	0.00	1,078.00
MED/SURG SUPPLY	43,331.00	98,624.95	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	39,297.00	5,149.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,962.00	6,127.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	22,466.00	1,355.00
EKG/ECG	1,815.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	19,273.00	1,016.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	166,791.00	33,741.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	288.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,632.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,315.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,930.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	28,398.35	4,932.44
RADIOLOGY THERAPEUTIC	2,408.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,276.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	81,932.00	17,031.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,790.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	72,369.00	39,844.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,904.00	0.00			
			TOTAL ANCILLARY	532,303.82	212,977.52
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	532,303.82	212,977.52

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

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

Run Date: 08/24/2017
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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROCKDALE MEDICAL CENTER
1412 MILSTEAD AVENUE, NE
CONYERS,GA 30012-3877

PROVIDER NUMBER
000001603A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/15	THROUGH	09/30/16
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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	38,587,535.54	ADJUSTMENTS	563,229.62
COVERED CHARGES	38,138,623.02	CONTRACTUAL ALLOW	32,759,690.04
NON-COVERD CHARGES	448,912.52	TOTAL MEDICAID LIAB	5,378,932.98
		LESS: COB	32,885.02
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,346,047.96

TOTAL NUMBER OF ADMISSIONS 707

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,120		0	3,335,422.80		216,878.24
ROUTINE NURSERY	192		0	306,640.00		22,580.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,312		0	3,642,062.80		239,458.24
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	480		0	1,999,200.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	480		0	1,999,200.00		0.00
TOTAL ACCOMODATIONS	2,792		0	5,641,262.80		239,458.24

SUMMARY TYPE I
 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 10/01/15 THROUGH 09/30/16
 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	2,407,164.14	0.00	OTHER LAB	167,394.16	0.00
MED/SURG SUPPLY	1,275,586.50	2,514.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,639,877.83	852.66	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	706,837.29	0.00	OTHER THERAPEUTIC SVC	0.00	14,883.52
CT SCAN	2,277,083.52	15,432.18	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	420,824.70	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	497,370.60	0.00	MRI SERVICES	462,068.55	0.00
IV THERAPY	76,746.87	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,202,730.76	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	668,070.27	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,849,399.53	2,021.76	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	980,817.96	0.00	AMBULANCE	0.00	0.00
GI SERVICES	226,137.50	3,067.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,286,171.67	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	484,171.28	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	195,599.19	0.00	INJECTABLE DRUGS	5,212,875.10	0.00
RADIOLOGY THERAPEUTIC	228,433.50	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	224,760.38	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	66,082.70	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	179,941.44	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,874.70	1,170.99	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	382,193.00	0.00
LITHOTRIPSY	23,952.50	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	167,848.69	62,800.92			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	193,536.50	89,630.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	385,494.63	0.00			
AUDIOLOGY	0.00	17,080.00			
CARDIOLOGY	1,522,482.75	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	16,384.97	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	61,447.04	0.00			
			TOTAL ANCILLARY	32,497,360.22	209,454.28
			TOTAL ACCOMODATIONS	5,641,262.80	239,458.24
			TOTAL CHARGES	38,138,623.02	448,912.52

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

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	299,095.46	ADJUSTMENTS	0.00
COVERED CHARGES	293,172.25	CONTRACTUAL ALLOW	213,266.53
NON-COVERD CHARGES	5,923.21	TOTAL MEDICAID LIAB	79,905.72
		LESS: COB	79,905.72
		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	27		0	42,840.00		3,060.00
ROUTINE NURSERY	7		0	10,815.00		2,260.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	34		0	53,655.00		5,320.00
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	34		0	53,655.00		5,320.00

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 10/01/15 THROUGH 09/30/16
 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	19,555.82	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	12,329.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	28,810.89	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,333.07	0.00	OTHER THERAPEUTIC SVC	0.00	319.95
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	779.35	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,082.48	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	91,866.29	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	24,519.03	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,676.07	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,608.74	0.00	INJECTABLE DRUGS	22,376.77	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	172.80	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	1,537.25	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	283.26			
CARDIOLOGY	4,649.40	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	220.29	0.00			
			TOTAL ANCILLARY	239,517.25	603.21
			TOTAL ACCOMODATIONS	53,655.00	5,320.00
			TOTAL CHARGES	293,172.25	5,923.21

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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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	31,156,782.12	ADJUSTMENTS	99,508.50
COVERED CHARGES	29,239,487.78	CONTRACTUAL ALLOW	27,247,221.09
NON-COVERD CHARGES	1,917,294.34	TOTAL MEDICAID LIAB	1,992,266.69
		LESS: COB	240.00
		LESS: COPAYMENT	3,720.00
		REIMBURSEMENT	1,988,306.69
		ALL OTHER	1,782,009.84
		FEE SCHEDULE-LAB	179,824.91
		INJECTABLE DRUGS	26,471.94

TOTAL NUMBER OF CLAIMS 5,125

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

CARTERSVILLE MEDICAL CENTER PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
 960 JOE FRANK HARRIS PKWY SE 000001625A SERVICE DATES 10/01/15 THROUGH 09/30/16
 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	655,813.60	1,159.92	OTHER LAB	187,148.07	0.00
MED/SURG SUPPLY	696,784.50	1,976.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	6,075.32	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,342,490.65	5,136.21	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,835,142.60	383,209.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	19,724.04	FEE SCHEDULE LAB	7,003,465.04	277,460.74
EKG/ECG	728,266.72	2,338.05	MRI SERVICES	349,303.59	72,055.98
IV THERAPY	810,743.36	8,246.82	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,896,693.79	201,327.39	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	60,491.04	5,027.29	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	117,424.08	10,096.92	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,184,460.22	1,090.93	AMBULANCE	0.00	0.00
GI SERVICES	267,627.70	30,719.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,354,925.69	19,033.07	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	728,181.37	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	227,482.38	41,453.19
RADIOLOGY THERAPEUTIC	630,554.86	554,340.58	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	12,918.96	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,596.78	8,133.49	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	5,983.20	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	17,751.56	4,263.30	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	131,386.00	0.00
LITHOTRIPSY	11,976.25	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	537,168.78	63,286.98			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,973.50	6,109.25			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	524,322.18	96,114.03			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	628,970.13	75,407.76			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,869.99	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	295,473.35	4,605.62			
			TOTAL ANCILLARY	29,239,487.78	1,917,294.34
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	29,239,487.78	1,917,294.34

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

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	288,731.21	ADJUSTMENTS	0.00
COVERED CHARGES	227,934.69	CONTRACTUAL ALLOW	158,984.08
NON-COVERD CHARGES	60,796.52	TOTAL MEDICAID LIAB	68,950.61
		LESS: COB	68,935.80
		LESS: COPAYMENT	14.81
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 65

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 10/01/15 THROUGH 09/30/16
 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	8,831.42	0.00	OTHER LAB	11,928.60	0.00
MED/SURG SUPPLY	7,876.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,799.77	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,486.53	17,814.52	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	64,770.80	1,905.93
EKG/ECG	5,455.45	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,572.83	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,529.53	26,585.63	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,728.64	2,992.56	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	17,088.27	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	4,275.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	65,971.85	83.05	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,843.57	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,057.80	493.83
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	372.60	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	5,934.00	6,646.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,623.33	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,063.70	0.00			
			TOTAL ANCILLARY	227,934.69	60,796.52
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	227,934.69	60,796.52

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,943,841.65	ADJUSTMENTS	970.92
COVERED CHARGES	1,862,809.46	CONTRACTUAL ALLOW	1,832,678.93
NON-COVERD CHARGES	81,032.19	TOTAL MEDICAID LIAB	30,130.53
		LESS: COB	0.00
		LESS: COPAYMENT	1,120.10
		REIMBURSEMENT	29,010.43
		TOTAL NUMBER OF CLAIMS	540

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

CARTERSVILLE MEDICAL CENTER PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
 960 JOE FRANK HARRIS PKWY SE 000001625A SERVICE DATES 10/01/15 THROUGH 09/30/16
 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	26,926.02	0.00	OTHER LAB	2,012.58	0.00
MED/SURG SUPPLY	9,015.00	582.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	240.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	121,943.59	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	272,191.29	37,398.65	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	537,599.85	24,664.75
EKG/ECG	41,305.55	0.00	MRI SERVICES	22,953.24	5,497.47
IV THERAPY	51,711.26	902.56	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,324.32	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	701,523.79	2,085.06	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,353.11	1,053.23
RADIOLOGY THERAPEUTIC	15,400.26	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	21,297.65	7,064.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	844.75	872.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	11,565.99	671.22			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,841.21	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,862,809.46	81,032.19
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,862,809.46	81,032.19

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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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,343.69	ADJUSTMENTS	0.00
COVERED CHARGES	3,343.69	CONTRACTUAL ALLOW	2,116.36
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1,227.33
		LESS: COB	1,224.33
		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

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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	113.13	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	1,062.45	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,168.11	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,343.69	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,343.69	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

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	510,512.04	ADJUSTMENTS	0.00
COVERED CHARGES	480,882.51	CONTRACTUAL ALLOW	448,190.53
NON-COVERD CHARGES	29,629.53	TOTAL MEDICAID LIAB	32,691.98
		LESS: COB	0.00
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	32,661.98

TOTAL NUMBER OF CLAIMS 6

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	10/01/15	THROUGH	09/30/16
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	8,619.90	0.00	OTHER LAB	1,647.00	0.00
MED/SURG SUPPLY	42,035.00	50.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,047.60	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,453.63	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,151.28	FEE SCHEDULE LAB	21,629.16	33.48
EKG/ECG	6,234.80	0.00	MRI SERVICES	4,984.20	0.00
IV THERAPY	347.22	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	84,182.54	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	29,246.90	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,083.68	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,436.94	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,912.05	2,391.93
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	792.99	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	268.65	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	29,054.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,995.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	11,565.99	671.22			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	211,556.61	24,269.98			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,850.04	0.00			
			TOTAL ANCILLARY	480,882.51	29,629.53
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	480,882.51	29,629.53

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: 08/24/2017
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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	10/01/15	THROUGH	09/30/16
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000001636A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	167,212,578.20	ADJUSTMENTS	16,962,560.96
COVERED CHARGES	160,936,629.52	CONTRACTUAL ALLOW	108,782,339.16
NON-COVERD CHARGES	6,275,948.68	TOTAL MEDICAID LIAB	52,154,290.36
		LESS: COB	408,850.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	51,745,439.86

TOTAL NUMBER OF ADMISSIONS 2,573

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	10,274		38	13,381,131.00		4,931,697.00
ROUTINE NURSERY	700		0	1,802,419.50		16,364.50
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	10,974		38	15,183,550.50		4,948,061.50
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	1,846		0	10,798,164.00		0.00
PED ICU	4,872		0	21,486,573.50		39,055.50
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	6,718		0	32,284,737.50		39,055.50
TOTAL ACCOMODATIONS	17,692		38	47,468,288.00		4,987,117.00

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,050,316.42	46,075.35	OTHER LAB	294,194.50	0.00
MED/SURG SUPPLY	5,763,201.35	62,517.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	15,695,124.05	107,760.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,008,932.00	501.00	OTHER THERAPEUTIC SVC	21,828.50	114,494.00
CT SCAN	1,421,299.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	674,442.00	396.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	76,250.50	0.00	MRI SERVICES	1,258,583.00	0.00
IV THERAPY	44,963.00	677.00	PROFESSIONAL FEES	0.00	5,638.50
OPERATING ROOM	9,640,324.00	2,197.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	24,658,767.20	233,059.30	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,337,732.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	11,907.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,447,581.50	31,918.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	575,802.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	730,746.00	0.00	INJECTABLE DRUGS	39,625.00	0.00
RADIOLOGY THERAPEUTIC	300,620.50	22,242.50	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	337,661.50	198.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	329,002.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	12,600.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	502.50	31,926.00	TRAUMA RESPONSE	0.00	26,137.50
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,520,745.50	24,131.78
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	348,550.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,069,126.00	384,561.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	99,006.50	6,536.00			
AUDIOLOGY	55,471.00	0.00			
CARDIOLOGY	857,454.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,598,219.00	1,171.50			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	200,363.00	174,092.00			
			TOTAL ANCILLARY	113,468,341.52	1,288,831.68
			TOTAL ACCOMODATIONS	47,468,288.00	4,987,117.00
			TOTAL CHARGES	160,936,629.52	6,275,948.68

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

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

Run Date: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,667,720.50	ADJUSTMENTS	0.00
COVERED CHARGES	8,405,915.00	CONTRACTUAL ALLOW	2,482,419.25
NON-COVERD CHARGES	261,805.50	TOTAL MEDICAID LIAB	5,923,495.75
		LESS: COB	5,923,495.75
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 162

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	459		0	575,918.00		164,687.00
ROUTINE NURSERY	41		0	107,015.50		1,448.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	500		0	682,933.50		166,135.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	203		0	1,179,990.00		0.00
PED ICU	114		1	499,257.00		4,339.50
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	317		1	1,679,247.00		4,339.50
TOTAL ACCOMODATIONS	817		1	2,362,180.50		170,474.50

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,120,022.25	0.00	OTHER LAB	8,728.00	0.00
MED/SURG SUPPLY	300,386.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	922,837.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	124,017.00	0.00	OTHER THERAPEUTIC SVC	1,894.50	3,507.50
CT SCAN	74,862.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	29,364.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,048.50	0.00	MRI SERVICES	84,013.00	0.00
IV THERAPY	1,748.00	0.00	PROFESSIONAL FEES	0.00	84,749.50
OPERATING ROOM	649,855.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,173,020.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	296,708.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	325,524.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	40,342.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	97,591.00	0.00	INJECTABLE DRUGS	3,500.00	0.00
RADIOLOGY THERAPEUTIC	8,614.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,130.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,446.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,026.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	276,928.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	25,044.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	83,197.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	20,641.50	1,047.50			
AUDIOLOGY	3,277.50	0.00			
CARDIOLOGY	79,428.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	253,438.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,127.00	1,000.00			
			TOTAL ANCILLARY	6,043,734.50	91,331.00
			TOTAL ACCOMODATIONS	2,362,180.50	170,474.50
			TOTAL CHARGES	8,405,915.00	261,805.50

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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	55,666,126.37	ADJUSTMENTS	1,213,539.11
COVERED CHARGES	51,177,776.09	CONTRACTUAL ALLOW	37,798,819.19
NON-COVERD CHARGES	4,488,350.28	TOTAL MEDICAID LIAB	13,378,956.90
		LESS: COB	34,179.75
		LESS: COPAYMENT	231.00
		REIMBURSEMENT	13,344,546.15
		ALL OTHER	11,964,004.70
		FEE SCHEDULE-LAB	489,574.06
		INJECTABLE DRUGS	890,967.39
		TOTAL NUMBER OF CLAIMS	20,149

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	918,315.75	10,332.00	OTHER LAB	401,093.00	5,894.50
MED/SURG SUPPLY	2,828,483.85	2,916.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,650,061.50	12,913.50	OTHER THERAPEUTIC SVC	0.00	3,662.50
CT SCAN	1,839,277.00	143,764.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,875,434.00	95,042.50	FEE SCHEDULE LAB	8,133,021.43	808,921.09
EKG/ECG	34,815.00	1,442.50	MRI SERVICES	3,785,750.50	325,593.50
IV THERAPY	849,393.00	51,616.50	PROFESSIONAL FEES	0.00	5,348.50
OPERATING ROOM	6,087,788.06	474,357.69	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	303,467.00	98,639.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,554,922.50	1,114.00	AMBULANCE	0.00	0.00
GI SERVICES	97,870.00	29,669.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,122,013.50	29,976.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	604,827.00	639.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,906,754.50	1,576,814.50
RADIOLOGY THERAPEUTIC	367,658.50	16,005.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	691,632.50	69,019.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	564,085.50	40,131.50	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,068,979.00	215,312.50	TRAUMA RESPONSE	0.00	55,747.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	184,500.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	683,019.50	20,917.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,084,919.50	18,917.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	243,396.00	16,825.50			
AUDIOLOGY	241,751.00	23,554.00			
CARDIOLOGY	65,796.50	51,425.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,742,978.00	5,626.50			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,245,772.00	276,212.50			
			TOTAL ANCILLARY	51,177,776.09	4,488,350.28
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	51,177,776.09	4,488,350.28

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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016239080710	02/05/16 - 02/05/16	09/05/16	0.00	0.00	0.00	0.00	0.00
932	2017069076478	03/14/16 - 03/14/16	03/20/17	0.00	0.00	0.00	1,366.59	0.00
932	2017069076478	03/15/16 - 03/15/16	03/20/17	0.00	0.00	0.00	1,366.59	0.00
932	2017069076478	03/16/16 - 03/16/16	03/20/17	0.00	0.00	0.00	1,366.59	0.00
932	2017069076478	03/17/16 - 03/17/16	03/20/17	0.00	0.00	0.00	1,366.59	0.00
932	2017069076478	03/18/16 - 03/18/16	03/20/17	0.00	0.00	0.00	1,366.59	0.00
932	2017069076478	03/21/16 - 03/21/16	03/20/17	0.00	0.00	0.00	1,366.59	0.00
932	2017069076478	03/22/16 - 03/22/16	03/20/17	0.00	0.00	0.00	1,366.59	0.00
932	2017069076478	03/23/16 - 03/23/16	03/20/17	0.00	0.00	0.00	1,366.59	0.00
932	2017069076478	03/24/16 - 03/24/16	03/20/17	0.00	0.00	0.00	1,366.59	0.00
932	2017069076478	03/25/16 - 03/25/16	03/20/17	0.00	0.00	0.00	1,366.59	0.00
932	2017069076478	03/28/16 - 03/28/16	03/20/17	0.00	0.00	0.00	1,366.59	0.00
932	2017069076478	03/29/16 - 03/29/16	03/20/17	0.00	0.00	0.00	1,366.59	0.00
932	2017069076478	03/30/16 - 03/30/16	03/20/17	0.00	0.00	0.00	1,366.59	0.00
932	2017069076478	03/31/16 - 03/31/16	03/20/17	0.00	0.00	0.00	1,366.59	0.00
TOTAL				0.00	0.00	0.00	19,132.26	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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,747,410.25	ADJUSTMENTS	0.00
COVERED CHARGES	1,492,364.50	CONTRACTUAL ALLOW	309,709.13
NON-COVERD CHARGES	255,045.75	TOTAL MEDICAID LIAB	1,182,655.37
		LESS: COB	1,182,649.37
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 340

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

CHILDREN'S HEALTHCARE OF ATLANTA PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
 1001 JOHNSON FERRY RD NE 000001636A SERVICE DATES 01/01/16 THROUGH 12/31/16
 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	28,947.25	0.00	OTHER LAB	4,266.50	0.00
MED/SURG SUPPLY	94,885.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,897.50	628.00	OTHER THERAPEUTIC SVC	0.00	343.00
CT SCAN	25,546.50	17,777.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	27,592.00	1,037.50	FEE SCHEDULE LAB	217,255.00	13,302.50
EKG/ECG	930.00	620.00	MRI SERVICES	139,309.50	40,045.00
IV THERAPY	3,309.50	1,215.50	PROFESSIONAL FEES	0.00	18,556.00
OPERATING ROOM	259,886.00	80,096.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,095.00	375.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	196,527.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	3,399.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	101,926.00	371.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	32,110.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	73,033.25	38,181.75
RADIOLOGY THERAPEUTIC	46,921.50	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,798.50	982.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,655.50	5,630.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,877.00	5,963.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	20,884.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,016.00	1,227.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	27,430.00	4,724.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	584.50	1,905.00			
CARDIOLOGY	1,228.50	18,226.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	105,278.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	29,173.50	439.50			
			TOTAL ANCILLARY	1,492,364.50	255,045.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,492,364.50	255,045.75

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

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016047000041	01/25/16 - 01/25/16	02/22/16	0.00	0.00	0.00	4,961.88	0.00
932	2016047000041	01/26/16 - 01/26/16	02/22/16	0.00	0.00	0.00	4,961.88	0.00
932	2016047000041	01/27/16 - 01/27/16	02/22/16	0.00	0.00	0.00	4,961.88	0.00
932	2016047000041	01/28/16 - 01/28/16	02/22/16	0.00	0.00	0.00	4,961.88	0.00
932	2016047000041	01/29/16 - 01/29/16	02/22/16	0.00	0.00	0.00	4,961.88	0.00
TOTAL				0.00	0.00	0.00	24,809.40	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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,611,795.50	ADJUSTMENTS	1,566.32
COVERED CHARGES	1,486,233.25	CONTRACTUAL ALLOW	1,415,748.85
NON-COVERD CHARGES	125,562.25	TOTAL MEDICAID LIAB	70,484.40
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	70,478.40
		TOTAL NUMBER OF CLAIMS	1,260

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,716.75	0.00	OTHER LAB	28,165.50	0.00
MED/SURG SUPPLY	34,010.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	96,466.50	269.00	OTHER THERAPEUTIC SVC	0.00	348.50
CT SCAN	14,071.00	34,298.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,980.00	8,019.00	FEE SCHEDULE LAB	296,122.00	38,745.00
EKG/ECG	4,340.00	0.00	MRI SERVICES	0.00	6,510.00
IV THERAPY	1,096.50	0.00	PROFESSIONAL FEES	0.00	1,152.00
OPERATING ROOM	21,652.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,905.00	196.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,949.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	903,866.00	1,532.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,278.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,516.75	12,008.25
RADIOLOGY THERAPEUTIC	0.00	275.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	891.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	464.00	414.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,569.50	184.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,871.50	6,748.50			
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	639.50			
CARDIOLOGY	0.00	2,644.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,505.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,687.50	10,687.50			
			TOTAL ANCILLARY	1,486,233.25	125,562.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,486,233.25	125,562.25

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

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	36,043.50	ADJUSTMENTS	0.00
COVERED CHARGES	29,619.75	CONTRACTUAL ALLOW	6,611.21
NON-COVERD CHARGES	6,423.75	TOTAL MEDICAID LIAB	23,008.54
		LESS: COB	23,008.54
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	10

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,157.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,593.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,349.00	250.50	OTHER THERAPEUTIC SVC	0.00	343.00
CT SCAN	0.00	1,838.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,881.00	1,522.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	2,183.00
OPERATING ROOM	3,224.00	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	1,114.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,643.00	178.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	426.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	147.50	108.75
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	29,619.75	6,423.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	29,619.75	6,423.75

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: 08/24/2017
Run Time: 02:22:13
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,394,355.89	ADJUSTMENTS	157,228.17
COVERED CHARGES	7,135,327.89	CONTRACTUAL ALLOW	5,973,051.94
NON-COVERD CHARGES	259,028.00	TOTAL MEDICAID LIAB	1,162,275.95
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,162,275.95
		TOTAL NUMBER OF CLAIMS	140

SUMMARY TYPE VII
 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 01/01/16 THROUGH 12/31/16
 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	69,481.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	647,983.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,052.50	0.00	OTHER THERAPEUTIC SVC	0.00	701.50
CT SCAN	14,113.00	1,838.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	134,312.00	3,624.00	FEE SCHEDULE LAB	126,785.14	9,520.00
EKG/ECG	0.00	405.00	MRI SERVICES	8,932.00	17,418.50
IV THERAPY	28,527.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,013,726.50	131,434.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	28,841.50	8,928.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	586,256.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	36,459.50	12,552.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	31,788.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	47,539.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,485,404.50	35,911.00
RADIOLOGY THERAPEUTIC	14,516.00	1,100.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	121,468.50	245.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	84,732.00	878.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	12,044.00	4,000.50	TRAUMA RESPONSE	0.00	4,546.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,431,614.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,098.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	29,920.50	85.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	486.50	0.00			
CARDIOLOGY	2,644.00	7,840.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	80,101.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	79,500.00	18,000.00			
			TOTAL ANCILLARY	7,135,327.89	259,028.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,135,327.89	259,028.00

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: 08/24/2017
Run Time: 02:22:18
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	675,489.75	ADJUSTMENTS	0.00
COVERED CHARGES	633,503.50	CONTRACTUAL ALLOW	-20,523.00
NON-COVERD CHARGES	41,986.25	TOTAL MEDICAID LIAB	654,026.50
		LESS: COB	654,026.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	12

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER
 000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,602.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	44,180.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,281.00	0.00
EKG/ECG	202.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	69,126.00	38,973.50	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	48,228.00	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	3,621.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	134,758.25	2,507.25
RADIOLOGY THERAPEUTIC	4,548.50	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	101.00	505.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	319,116.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,625.00	0.00			
			TOTAL ANCILLARY	633,503.50	41,986.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	633,503.50	41,986.25

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

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

Run Date: 08/24/2017
 Run Time: 04:02:56
 Page: 1

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	279,060.42	ADJUSTMENTS	12,524.90
COVERED CHARGES	164,904.38	CONTRACTUAL ALLOW	60,247.02
NON-COVERD CHARGES	114,156.04	TOTAL MEDICAID LIAB	104,657.36
		LESS: COB	1,718.42
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	102,938.94

TOTAL NUMBER OF ADMISSIONS 19

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	53		0	46,872.00		112,970.64
ROUTINE NURSERY	0		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	46,872.00		112,970.64
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	53		0	46,872.00		112,970.64

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39,100.09	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,464.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	14,433.16	0.00	EDUCATION & TRAINING	143.16	0.00
RADIOLOGY-DIAGNOSTIC	1,703.20	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,325.55	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	214.29	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,586.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,399.22	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,255.66	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,679.35	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,630.35	0.00			
BLOOD	1,185.40	0.00			
BLOOD STORAGE & PRO.	2,912.00	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	0.00	0.00			
			TOTAL ANCILLARY	118,032.38	1,185.40
			TOTAL ACCOMODATIONS	46,872.00	112,970.64
			TOTAL CHARGES	164,904.38	114,156.04

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

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

Run Date: 08/24/2017
 Run Time: 04:02:57
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,593.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,517.00	CONTRACTUAL ALLOW	1,162.01
NON-COVERD CHARGES	2,076.00	TOTAL MEDICAID LIAB	1,354.99
		LESS: COB	1,354.99
		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	924.00		2,076.00
ROUTINE NURSERY	0		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	924.00		2,076.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	924.00		2,076.00

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

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

Run Date: 08/24/2017
 Run Time: 04:02:57
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,103.72	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	14.08	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	475.20	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,593.00	0.00
			TOTAL ACCOMODATIONS	924.00	2,076.00
			TOTAL CHARGES	2,517.00	2,076.00

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: 08/24/2017
Run Time: 04:02:57
Page: 5

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	984,531.46	ADJUSTMENTS	60,550.94
COVERED CHARGES	923,673.54	CONTRACTUAL ALLOW	553,317.75
NON-COVERD CHARGES	60,857.92	TOTAL MEDICAID LIAB	370,355.79
		LESS: COB	552.20
		LESS: COPAYMENT	630.00
		REIMBURSEMENT	369,173.59
		ALL OTHER	330,147.13
		FEE SCHEDULE-LAB	39,026.46
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	1,063

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	82,971.10	149.40	OTHER LAB	7,199.70	0.00
MED/SURG SUPPLY	8,099.49	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,578.40	EDUCATION & TRAINING	0.00	429.48
RADIOLOGY-DIAGNOSTIC	53,363.85	588.90	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	101,780.45	14,596.95	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	11,090.64	1,950.66	FEE SCHEDULE LAB	190,022.53	19,219.08
EKG/ECG	23,970.55	517.35	MRI SERVICES	0.00	0.00
IV THERAPY	37,221.55	3,364.30	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	81,264.14	7,231.09	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	16,758.09	3,765.53	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	195,980.38	4,647.60	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,214.40	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	22,019.90	708.70			
BLOOD	577.20	0.00			
BLOOD STORAGE & PRO.	1,820.00	1,185.40			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	288.20	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	88,031.37	925.08			
			TOTAL ANCILLARY	923,673.54	60,857.92
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	923,673.54	60,857.92

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

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	221.10	ADJUSTMENTS	0.00
COVERED CHARGES	221.10	CONTRACTUAL ALLOW	89.50
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	131.60
		LESS: COB	131.60
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 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	221.10	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	221.10	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	221.10	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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	84,247.12	ADJUSTMENTS	194.00
COVERED CHARGES	79,651.05	CONTRACTUAL ALLOW	73,201.05
NON-COVERD CHARGES	4,596.07	TOTAL MEDICAID LIAB	6,450.00
		LESS: COB	0.00
		LESS: COPAYMENT	282.00
		REIMBURSEMENT	6,168.00
		TOTAL NUMBER OF CLAIMS	129

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,173.22	37.35	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	47.72
RADIOLOGY-DIAGNOSTIC	3,074.35	374.30	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,674.05	1,840.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,096.60	2,116.64
EKG/ECG	1,207.15	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,718.08	179.31	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	690.79	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	38,090.78	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	570.55	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	355.48	0.00			
			TOTAL ANCILLARY	79,651.05	4,596.07
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	79,651.05	4,596.07

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

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	01/01/16	THROUGH	12/31/16
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

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	42,745.81	ADJUSTMENTS	0.00
COVERED CHARGES	42,745.81	CONTRACTUAL ALLOW	33,020.03
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	9,725.78
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	9,722.78
		TOTAL NUMBER OF CLAIMS	2

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,990.74	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	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	39,453.15	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	1,301.92	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	42,745.81	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	42,745.81	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: 08/24/2017
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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	01/01/16	THROUGH	12/31/16
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: 08/24/2017
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

WELLSTAR ATLANTA MEDICAL CENTER , INC
 1170 CLEVELAND AVE
 EAST POINT,GA 30344-3615

PROVIDER NUMBER 000001713A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	49,294.46	ADJUSTMENTS	0.00
COVERED CHARGES	47,994.46	CONTRACTUAL ALLOW	39,777.58
NON-COVERD CHARGES	1,300.00	TOTAL MEDICAID LIAB	8,216.88
		LESS: COB	56.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,160.88

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	4		0	5,236.00		1,300.00
ROUTINE NURSERY	2		0	2,160.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	6		0	7,396.00		1,300.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	7,396.00		1,300.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

WELLSTAR ATLANTA MEDICAL CENTER , INC
 1170 CLEVELAND AVE
 EAST POINT,GA 30344-3615

PROVIDER NUMBER
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,778.24	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,856.78	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,448.41	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	694.13	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	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	9,638.93	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,133.65	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	9,377.46	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	58.96	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	2,873.30	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	137.94	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	600.66	0.00			
			TOTAL ANCILLARY	40,598.46	0.00
			TOTAL ACCOMODATIONS	7,396.00	1,300.00
			TOTAL CHARGES	47,994.46	1,300.00

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

WELLSTAR ATLANTA MEDICAL CENTER , INC
 1170 CLEVELAND AVE
 EAST POINT,GA 30344-3615

PROVIDER NUMBER
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	57,306.49	ADJUSTMENTS	0.00
COVERED CHARGES	55,681.49	CONTRACTUAL ALLOW	21,852.10
NON-COVERD CHARGES	1,625.00	TOTAL MEDICAID LIAB	33,829.39
		LESS: COB	33,829.39
		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	6,545.00		1,625.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5		0	6,545.00		1,625.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	5		0	6,545.00		1,625.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR ATLANTA MEDICAL CENTER , INC
 1170 CLEVELAND AVE
 EAST POINT,GA 30344-3615

PROVIDER NUMBER
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,545.33	0.00	OTHER LAB	1,657.46	0.00
MED/SURG SUPPLY	3,563.15	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,927.76	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,635.59	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,818.91	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,897.85	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,377.46	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,156.89	0.00	INJECTABLE DRUGS	3,014.20	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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,541.89	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	0.00	0.00			
			TOTAL ANCILLARY	49,136.49	0.00
			TOTAL ACCOMODATIONS	6,545.00	1,625.00
			TOTAL CHARGES	55,681.49	1,625.00

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: 08/24/2017
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WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	540,932.46	ADJUSTMENTS	3,821.90
COVERED CHARGES	464,583.50	CONTRACTUAL ALLOW	429,154.43
NON-COVERD CHARGES	76,348.96	TOTAL MEDICAID LIAB	35,429.07
		LESS: COB	1,391.24
		LESS: COPAYMENT	120.00
		REIMBURSEMENT	33,917.83
		ALL OTHER	28,943.45
		FEE SCHEDULE-LAB	4,078.77
		INJECTABLE DRUGS	895.61

TOTAL NUMBER OF CLAIMS 107

WELLSTAR ATLANTA MEDICAL CENTER , INC
 1170 CLEVELAND AVE
 EAST POINT,GA 30344-3615

PROVIDER NUMBER
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,597.16	17.48	OTHER LAB	2,990.11	0.00
MED/SURG SUPPLY	44,863.12	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	28,665.82	1,400.49	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,933.01	16,156.36	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	69,233.52	1,483.85
EKG/ECG	6,807.78	0.00	MRI SERVICES	8,879.11	12,898.19
IV THERAPY	22,786.16	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	52,557.21	6,893.49	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	716.39	1,251.47	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	29,081.17	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,015.69	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	87,173.69	3,277.11	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,058.12	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	29,373.17	12,734.26
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	8,169.00	236.91	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	3,831.08	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,429.46	1,749.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	8,019.24			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,448.38	3,556.31			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,974.35	6,674.00			
			TOTAL ANCILLARY	464,583.50	76,348.96
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	464,583.50	76,348.96

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 ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,113.45	ADJUSTMENTS	0.00
COVERED CHARGES	17,172.28	CONTRACTUAL ALLOW	13,936.83
NON-COVERD CHARGES	6,941.17	TOTAL MEDICAID LIAB	3,235.45
		LESS: COB	3,229.45
		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

WELLSTAR ATLANTA MEDICAL CENTER , INC
 1170 CLEVELAND AVE
 EAST POINT,GA 30344-3615

PROVIDER NUMBER
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	995.34	743.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,238.55	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,200.40	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,763.18	0.00
EKG/ECG	756.42	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,046.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	3,655.30	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	144.61	254.74	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,947.84	1,473.92	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,530.78	96.21
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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	548.41	717.50			
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	17,172.28	6,941.17
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,172.28	6,941.17

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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WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,759.99	ADJUSTMENTS	0.00
COVERED CHARGES	23,228.17	CONTRACTUAL ALLOW	22,445.01
NON-COVERD CHARGES	2,531.82	TOTAL MEDICAID LIAB	783.16
		LESS: COB	0.00
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	762.16
		TOTAL NUMBER OF CLAIMS	14

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR ATLANTA MEDICAL CENTER , INC
 1170 CLEVELAND AVE
 EAST POINT,GA 30344-3615

PROVIDER NUMBER
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,010.23	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	206.92	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,388.36	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,449.42	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,453.21	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,838.98	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,881.05	2,531.82			
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	23,228.17	2,531.82
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	23,228.17	2,531.82

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 ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,445.03	ADJUSTMENTS	0.00
COVERED CHARGES	2,445.03	CONTRACTUAL ALLOW	1,390.87
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1,054.16
		LESS: COB	1,048.16
		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

WELLSTAR ATLANTA MEDICAL CENTER , INC
 1170 CLEVELAND AVE
 EAST POINT,GA 30344-3615

PROVIDER NUMBER
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 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	562.87	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	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	1,882.16	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,445.03	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,445.03	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

WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/16	THROUGH	03/31/16
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: 08/24/2017
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/16	THROUGH	03/31/16
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

WELLSTAR ATLANTA MEDICAL CENTER , INC
 1170 CLEVELAND AVE
 EAST POINT,GA 30344-3615

PROVIDER NUMBER 000001713A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	597,317.41	ADJUSTMENTS	0.00
COVERED CHARGES	590,492.41	CONTRACTUAL ALLOW	537,844.37
NON-COVERD CHARGES	6,825.00	TOTAL MEDICAID LIAB	52,648.04
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	52,648.04

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	21		0	27,489.00		6,825.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	21		0	27,489.00		6,825.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	42		0	111,837.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	111,837.00		0.00
TOTAL ACCOMODATIONS	63		0	139,326.00		6,825.00

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

WELLSTAR ATLANTA MEDICAL CENTER , INC
 1170 CLEVELAND AVE
 EAST POINT,GA 30344-3615

PROVIDER NUMBER
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	171,162.42	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	28,936.81	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	49,455.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,202.74	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	48,163.24	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,967.87	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,891.05	0.00	MRI SERVICES	21,577.08	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	24,777.42	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	17,043.44	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,795.70	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,065.73	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,434.35	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,314.86	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	4,853.40	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,414.96	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	457.19	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	3,337.17	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,112.67	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	15,753.70	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	14,448.86	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	451,166.41	0.00
			TOTAL ACCOMODATIONS	139,326.00	6,825.00
			TOTAL CHARGES	590,492.41	6,825.00

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

WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/16	THROUGH	06/30/16
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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WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/16 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	86,238.29	ADJUSTMENTS	1,455.10
COVERED CHARGES	83,162.06	CONTRACTUAL ALLOW	76,585.52
NON-COVERD CHARGES	3,076.23	TOTAL MEDICAID LIAB	6,576.54
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	6,573.54
		ALL OTHER	6,089.61
		FEE SCHEDULE-LAB	435.67
		INJECTABLE DRUGS	48.26

TOTAL NUMBER OF CLAIMS 17

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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WELLSTAR ATLANTA MEDICAL CENTER , INC
 1170 CLEVELAND AVE
 EAST POINT,GA 30344-3615

PROVIDER NUMBER
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,337.23	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	754.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,667.51	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	26,399.28	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,640.03	756.42
EKG/ECG	756.42	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,506.28	717.50	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	287.00	509.48	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,132.53	0.00	AMBULANCE	0.00	0.00
GI SERVICES	7,176.04	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	20,499.14	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,864.54	1,092.83
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,141.31	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	83,162.06	3,076.23
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	83,162.06	3,076.23

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

WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/16	THROUGH	06/30/16
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: 08/24/2017
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WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/16 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,501.89	ADJUSTMENTS	0.00
COVERED CHARGES	17,326.95	CONTRACTUAL ALLOW	17,047.25
NON-COVERD CHARGES	174.94	TOTAL MEDICAID LIAB	279.70
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	267.70
		TOTAL NUMBER OF CLAIMS	5

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR ATLANTA MEDICAL CENTER , INC
 1170 CLEVELAND AVE
 EAST POINT,GA 30344-3615

PROVIDER NUMBER
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	90.36	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	15.57	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,505.35	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,380.47	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	412.69	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	6,417.38	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	505.13	174.94
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	17,326.95	174.94
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,326.95	174.94

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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WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/16	THROUGH	06/30/16
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

WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/16	THROUGH	06/30/16
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

WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/16	THROUGH	06/30/16
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

SOUTH GEORGIA MEDICAL CENTER
 2501 N PATTERSON ST
 VALDOSTA,GA 31602-1735

PROVIDER NUMBER 000001724A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	33,045,472.22	ADJUSTMENTS	1,149,396.26
COVERED CHARGES	32,054,674.92	CONTRACTUAL ALLOW	22,240,508.83
NON-COVERD CHARGES	990,797.30	TOTAL MEDICAID LIAB	9,814,166.09
		LESS: COB	26,128.31
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,788,037.78

TOTAL NUMBER OF ADMISSIONS 1,079

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	4,027	3	2,657,645.50	531,805.25
ROUTINE NURSERY	460	0	333,528.00	51,214.50
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4,487	3	2,991,173.50	583,019.75
SPECIAL CARE SERVICES				
CCU	211	0	357,760.00	0.00
ICU	669	0	1,132,449.75	0.00
NICU	35	0	53,515.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	915	0	1,543,724.75	0.00
TOTAL ACCOMODATIONS	5,402	3	4,534,898.25	583,019.75

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

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,262,926.17	30,462.30	OTHER LAB	167,134.50	0.00
MED/SURG SUPPLY	3,473,112.00	28,541.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,170,965.25	11,586.25	EDUCATION & TRAINING	9,915.00	37.25
RADIOLOGY-DIAGNOSTIC	366,911.75	186.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,537,428.25	6,319.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	197,950.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	202,080.25	0.00	MRI SERVICES	306,826.25	0.00
IV THERAPY	370,693.50	1,066.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,524,292.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	196,566.25	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,845,808.75	692.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	324,177.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	21,157.00	9,229.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	462,670.25	569.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	269,212.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	73,069.75	0.00	INJECTABLE DRUGS	2,642,049.00	145.00
RADIOLOGY THERAPEUTIC	26,994.25	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	64,880.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	52,115.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	246,250.00	985.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	25,781.25	846.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,248,822.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	147,990.75	22,417.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	413,799.00	290,266.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	61,162.00	0.00			
AUDIOLOGY	48,469.25	0.00			
CARDIOLOGY	1,011,602.25	0.00			
AMBULATORY SURGERY	176,004.75	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	24,096.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	546,864.00	4,426.25			
			TOTAL ANCILLARY	27,519,776.67	407,777.55
			TOTAL ACCOMODATIONS	4,534,898.25	583,019.75
			TOTAL CHARGES	32,054,674.92	990,797.30

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

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	306,826.25	ADJUSTMENTS	0.00
COVERED CHARGES	298,336.00	CONTRACTUAL ALLOW	79,651.43
NON-COVERD CHARGES	8,490.25	TOTAL MEDICAID LIAB	218,684.57
		LESS: COB	218,684.57
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 14

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	27		0	17,414.00		3,621.00
ROUTINE NURSERY	4		0	2,520.00		14.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	31		0	19,934.00		3,635.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	18		0	30,469.50		0.00
NICU	1		0	1,529.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	31,998.50		0.00
TOTAL ACCOMODATIONS	50		0	51,932.50		3,635.00

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35,082.00	0.00	OTHER LAB	2,655.00	0.00
MED/SURG SUPPLY	37,647.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	34,106.25	0.00	EDUCATION & TRAINING	105.25	0.00
RADIOLOGY-DIAGNOSTIC	2,987.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,247.75	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,376.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,167.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,702.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	14,152.25	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	17,375.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,377.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,736.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,916.75	0.00	INJECTABLE DRUGS	35,160.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	12,805.00	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	328.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,999.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,477.50	4,855.25			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	822.75	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	7,845.25	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,983.50	0.00			
			TOTAL ANCILLARY	246,403.50	4,855.25
			TOTAL ACCOMODATIONS	51,932.50	3,635.00
			TOTAL CHARGES	298,336.00	8,490.25

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

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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,594,692.60	ADJUSTMENTS	474,007.54
COVERED CHARGES	17,569,757.58	CONTRACTUAL ALLOW	13,095,778.48
NON-COVERD CHARGES	2,024,935.02	TOTAL MEDICAID LIAB	4,473,979.10
		LESS: COB	21,655.28
		LESS: COPAYMENT	9,957.35
		REIMBURSEMENT	4,442,366.47
		ALL OTHER	3,295,571.57
		FEE SCHEDULE-LAB	357,922.25
		INJECTABLE DRUGS	788,872.65

TOTAL NUMBER OF CLAIMS 9,420

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,649,283.46	668.24	OTHER LAB	101,177.50	1,261.75
MED/SURG SUPPLY	1,127,494.70	2,847.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	1,096.75	1,833.25
RADIOLOGY-DIAGNOSTIC	520,560.25	34,123.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,801,679.25	316,100.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	721.75	8,791.00	FEE SCHEDULE LAB	2,009,286.89	196,984.78
EKG/ECG	224,937.00	8,600.00	MRI SERVICES	223,564.25	45,615.75
IV THERAPY	983,538.50	5,244.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	861,076.08	149,321.18	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	372.00
RESPIRATORY SERVICES	180,631.50	32,019.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	378,851.00	849.75	AMBULANCE	0.00	0.00
GI SERVICES	3,962.50	4,447.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,312,438.00	16,718.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	665,699.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,417,930.79	495,688.70
RADIOLOGY THERAPEUTIC	210,385.50	132,704.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	222.50	4,298.75	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	528.50	13,449.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	5,910.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	40,786.25	5,096.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	139,431.00	1,157.75
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	404,945.50	175,906.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	55,137.75	52,220.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	125,681.00	8,617.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	251,391.75	210,477.75			
AMBULATORY SURGERY	182,073.38	69,114.62			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	21,666.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	673,578.28	24,494.75			
			TOTAL ANCILLARY	17,569,757.58	2,024,935.02
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,569,757.58	2,024,935.02

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

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	480,134.29	ADJUSTMENTS	0.00
COVERED CHARGES	382,048.35	CONTRACTUAL ALLOW	74,121.24
NON-COVERD CHARGES	98,085.94	TOTAL MEDICAID LIAB	307,927.11
		LESS: COB	307,757.94
		LESS: COPAYMENT	169.17
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 193

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,024.15	2,155.59	OTHER LAB	3,474.00	0.00
MED/SURG SUPPLY	41,048.25	1,801.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	187.50
RADIOLOGY-DIAGNOSTIC	5,808.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,536.75	31,664.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	286.00	FEE SCHEDULE LAB	33,160.00	2,511.00
EKG/ECG	3,096.00	344.00	MRI SERVICES	2,902.25	1,912.00
IV THERAPY	17,896.25	538.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	43,295.15	23,650.35	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,561.50	187.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	27,997.00	1,433.50	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,214.50	397.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	41,747.25	973.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	81,849.80	3,576.00
RADIOLOGY THERAPEUTIC	1,455.50	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	47.00	88.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	719.00	3,091.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,946.25	8,447.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,849.50	6,884.50			
AUDIOLOGY	0.00	517.50			
CARDIOLOGY	1,225.75	2,934.00			
AMBULATORY SURGERY	0.00	1,782.75			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,194.50	2,723.75			
			TOTAL ANCILLARY	382,048.35	98,085.94
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	382,048.35	98,085.94

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

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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	256,170.23	ADJUSTMENTS	160.37
COVERED CHARGES	236,656.48	CONTRACTUAL ALLOW	219,146.29
NON-COVERD CHARGES	19,513.75	TOTAL MEDICAID LIAB	17,510.19
		LESS: COB	5.13
		LESS: COPAYMENT	702.59
		REIMBURSEMENT	16,802.47
		TOTAL NUMBER OF CLAIMS	313

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,515.98	0.00	OTHER LAB	1,459.50	0.00
MED/SURG SUPPLY	10,649.50	161.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,104.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	30,855.00	10,449.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	40,393.00	4,126.25
EKG/ECG	2,752.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	13,393.50	101.25	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	1,172.25	187.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	91,762.25	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	9,257.75	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	47.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,990.25	3,872.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	418.00	616.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	775.50	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,110.75	0.00			
			TOTAL ANCILLARY	236,656.48	19,513.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	236,656.48	19,513.75

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,831.15	ADJUSTMENTS	0.00
COVERED CHARGES	9,752.40	CONTRACTUAL ALLOW	3,222.27
NON-COVERD CHARGES	2,078.75	TOTAL MEDICAID LIAB	6,530.13
		LESS: COB	6,518.13
		LESS: COPAYMENT	12.00
		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

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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	248.65	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	873.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	896.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,635.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,230.50	68.25
EKG/ECG	516.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	561.50	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	3,364.50	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	497.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	564.75	375.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,752.40	2,078.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,752.40	2,078.75

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

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,068,806.79	ADJUSTMENTS	60,967.53
COVERED CHARGES	1,932,735.45	CONTRACTUAL ALLOW	1,512,582.39
NON-COVERD CHARGES	136,071.34	TOTAL MEDICAID LIAB	420,153.06
		LESS: COB	0.00
		LESS: COPAYMENT	318.00
		REIMBURSEMENT	419,835.06
		TOTAL NUMBER OF CLAIMS	76

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	328,943.69	0.00	OTHER LAB	1,946.50	0.00
MED/SURG SUPPLY	94,220.50	2,374.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	191.50	0.00
RADIOLOGY-DIAGNOSTIC	26,413.00	10,763.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	29,752.25	9,825.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	395.75	FEE SCHEDULE LAB	39,185.25	2,232.75
EKG/ECG	4,988.00	172.00	MRI SERVICES	10,096.00	2,547.25
IV THERAPY	104,570.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	71,427.51	1,522.49	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,076.75	1,620.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,834.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,205.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,744.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	611,943.25	10,514.10
RADIOLOGY THERAPEUTIC	49,607.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	85.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	275,378.25	11,042.25
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,256.00	484.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	836.25	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	189,393.25	82,278.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	502.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	39,138.00	299.50			
			TOTAL ANCILLARY	1,932,735.45	136,071.34
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,932,735.45	136,071.34

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

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,660.95	ADJUSTMENTS	0.00
COVERED CHARGES	21,613.95	CONTRACTUAL ALLOW	5,736.88
NON-COVERD CHARGES	2,047.00	TOTAL MEDICAID LIAB	15,877.07
		LESS: COB	15,874.07
		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

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	535.95	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	422.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	118.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	509.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	18,818.50	2,047.00
RADIOLOGY THERAPEUTIC	1,111.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	99.25	0.00			
			TOTAL ANCILLARY	21,613.95	2,047.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	21,613.95	2,047.00

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: 08/24/2017
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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	10/01/15	THROUGH	09/30/16
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

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

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

Run Date: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,556,020.96	ADJUSTMENTS	157.38
COVERED CHARGES	1,280,906.98	CONTRACTUAL ALLOW	933,535.00
NON-COVERD CHARGES	275,113.98	TOTAL MEDICAID LIAB	347,371.98
		LESS: COB	0.00
		LESS: COPAYMENT	801.00
		REIMBURSEMENT	346,570.98
		ALL OTHER	337,235.00
		FEE SCHEDULE-LAB	9,198.01
		INJECTABLE DRUGS	137.97

TOTAL NUMBER OF CLAIMS 511

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	68,456.21	0.00	OTHER LAB	2,375.00	0.00
MED/SURG SUPPLY	125,708.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,411.25	165.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,026.00	54,687.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	377.00	FEE SCHEDULE LAB	37,443.50	2,185.50
EKG/ECG	688.00	0.00	MRI SERVICES	10,766.75	14,168.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	414,568.52	149,051.98	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	150,518.50	1,699.50	AMBULANCE	0.00	0.00
GI SERVICES	1,782.75	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	530.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	132,033.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,761.75	232.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	222.50	6,260.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	27,052.75	13,317.75
LITHOTRIPSY	43,887.75	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	35,275.75	1,938.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	955.00	1,103.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	23,176.50	29,824.50			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	127,389.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	35,876.75	103.50			
			TOTAL ANCILLARY	1,280,906.98	275,113.98
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,280,906.98	275,113.98

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
4280 N VALDOSTA ROAD
VALDOSTA,GA 31602-6814

PROVIDER NUMBER
000001724G

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,221.85	ADJUSTMENTS	0.00
COVERED CHARGES	10,210.10	CONTRACTUAL ALLOW	3,628.47
NON-COVERD CHARGES	11.75	TOTAL MEDICAID LIAB	6,581.63
		LESS: COB	6,572.63
		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

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	332.60	0.00	OTHER LAB	475.00	0.00
MED/SURG SUPPLY	616.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	396.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,232.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	634.00	11.75
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	1,417.50	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	1,142.25	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	1,094.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	833.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	37.25	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	0.00	0.00			
			TOTAL ANCILLARY	10,210.10	11.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,210.10	11.75

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: 08/24/2017
Run Time: 04:06:54
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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	10/01/15	THROUGH	09/30/16
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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	69,896.80	ADJUSTMENTS	0.00
COVERED CHARGES	66,078.80	CONTRACTUAL ALLOW	50,472.08
NON-COVERD CHARGES	3,818.00	TOTAL MEDICAID LIAB	15,606.72
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	15,600.72

TOTAL NUMBER OF CLAIMS 3

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,117.55	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,005.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	720.25	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	1,353.50	196.75
EKG/ECG	172.00	172.00	MRI SERVICES	0.00	0.00
IV THERAPY	303.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,189.75	3,449.25	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	3,834.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	397.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,430.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	804.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	862.75	0.00
LITHOTRIPSY	43,887.75	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	66,078.80	3,818.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	66,078.80	3,818.00

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

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	10/01/15	THROUGH	09/30/16
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

ST. FRANCIS HEALTH, LLC
 2122 MANCHESTER EXPY
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER 000001768A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,722,436.65	ADJUSTMENTS	118,297.78
COVERED CHARGES	19,399,396.28	CONTRACTUAL ALLOW	11,866,009.56
NON-COVERD CHARGES	1,323,040.37	TOTAL MEDICAID LIAB	7,533,386.72
		LESS: COB	69,975.86
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,463,410.86

TOTAL NUMBER OF ADMISSIONS 955

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5,567		0	3,422,475.00		1,263,887.50
ROUTINE NURSERY	74		0	40,765.00		199.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5,641		0	3,463,240.00		1,264,086.50
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	488		0	646,600.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	488		0	646,600.00		0.00
TOTAL ACCOMODATIONS	6,129		0	4,109,840.00		1,264,086.50

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

ST. FRANCIS HEALTH, LLC
 2122 MANCHESTER EXPY
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,443,630.89	0.00	OTHER LAB	60,322.50	0.00
MED/SURG SUPPLY	1,578,806.50	3,518.62	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,792,363.85	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	300,612.50	0.00	OTHER THERAPEUTIC SVC	0.00	274.00
CT SCAN	534,413.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	214,761.18	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	157,140.75	0.00	MRI SERVICES	215,819.50	1,390.00
IV THERAPY	120,468.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,441,890.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	77,720.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	771,882.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	289,124.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	177,469.75	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	558,217.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	67,144.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	303,770.50	0.00	INJECTABLE DRUGS	129,243.85	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	111,212.42	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	43,594.37	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	91,478.75	26,705.25	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	38.00	1,738.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,143,979.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	44,002.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	179,984.25	11,637.25			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	33,672.75	13,401.75			
AUDIOLOGY	11,730.00	0.00			
CARDIOLOGY	326,201.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	12,024.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	56,834.47	289.00			
			TOTAL ANCILLARY	15,289,556.28	58,953.87
			TOTAL ACCOMODATIONS	4,109,840.00	1,264,086.50
			TOTAL CHARGES	19,399,396.28	1,323,040.37

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

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

Run Date: 08/24/2017
 Run Time: 04:10:30
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SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

ST. FRANCIS HEALTH, LLC
 2122 MANCHESTER EXPY
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER 000001768A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	142,606.82	ADJUSTMENTS	0.00
COVERED CHARGES	117,596.82	CONTRACTUAL ALLOW	29,188.13
NON-COVERD CHARGES	25,010.00	TOTAL MEDICAID LIAB	88,408.69
		LESS: COB	88,408.69
		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	82		0	50,430.00		24,190.00
ROUTINE NURSERY	4		0	2,200.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	86		0	52,630.00		24,190.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	86		0	52,630.00		24,190.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

ST. FRANCIS HEALTH, LLC
 2122 MANCHESTER EXPY
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,632.32	0.00	OTHER LAB	600.00	0.00
MED/SURG SUPPLY	5,697.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	13,387.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	146.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,898.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,078.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	504.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	23,388.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	144.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,298.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,125.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,186.00	0.00	INJECTABLE DRUGS	100.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	820.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	782.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	64,966.82	820.00
			TOTAL ACCOMODATIONS	52,630.00	24,190.00
			TOTAL CHARGES	117,596.82	25,010.00

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: 08/24/2017
Run Time: 04:10:32
Page: 5

ST. FRANCIS HEALTH, LLC
2122 MANCHESTER EXPY
COLUMBUS,GA 31904-6878

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,659,141.50	ADJUSTMENTS	282,127.43
COVERED CHARGES	8,113,987.84	CONTRACTUAL ALLOW	6,141,892.20
NON-COVERD CHARGES	545,153.66	TOTAL MEDICAID LIAB	1,972,095.64
		LESS: COB	7,908.24
		LESS: COPAYMENT	3,502.26
		REIMBURSEMENT	1,960,685.14
		ALL OTHER	1,757,800.55
		FEE SCHEDULE-LAB	197,743.09
		INJECTABLE DRUGS	5,141.50

TOTAL NUMBER OF CLAIMS 4,754

ST. FRANCIS HEALTH, LLC
 2122 MANCHESTER EXPY
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	496,660.14	1,276.40	OTHER LAB	45,791.67	0.00
MED/SURG SUPPLY	573,370.25	896.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	391,365.59	1,947.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	732,281.75	104,645.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	52,225.50	12,320.81	FEE SCHEDULE LAB	1,742,603.72	88,560.00
EKG/ECG	196,471.00	3,207.50	MRI SERVICES	150,929.00	14,755.50
IV THERAPY	172,901.25	3,606.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	712,044.49	111,140.26	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	50,578.00	10,963.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	186,050.00	546.00	AMBULANCE	0.00	0.00
GI SERVICES	99,381.62	20,673.13	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,597,025.75	29,181.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	72,108.25	602.50	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	25,616.20	19,340.19
RADIOLOGY THERAPEUTIC	4,762.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	13,271.50	6,733.43	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	835.00	5,347.15	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	56,902.51	2,950.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	330.53	0.00	IMPL DEV CHARGE PATIENTS	64,500.00	3,122.25
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	102,223.75	11,091.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	13,913.00	6,286.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	40,350.25	22,020.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	340,086.50	61,950.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	105,809.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	73,599.12	1,988.79			
			TOTAL ANCILLARY	8,113,987.84	545,153.66
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,113,987.84	545,153.66

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

ST. FRANCIS HEALTH, LLC
2122 MANCHESTER EXPY
COLUMBUS,GA 31904-6878

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	189,377.45	ADJUSTMENTS	0.00
COVERED CHARGES	133,756.27	CONTRACTUAL ALLOW	63,159.97
NON-COVERD CHARGES	55,621.18	TOTAL MEDICAID LIAB	70,596.30
		LESS: COB	70,523.82
		LESS: COPAYMENT	72.48
		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

ST. FRANCIS HEALTH, LLC
 2122 MANCHESTER EXPY
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,789.17	95.25	OTHER LAB	415.00	0.00
MED/SURG SUPPLY	16,608.00	698.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,471.00	121.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	14,055.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	255.00	FEE SCHEDULE LAB	24,466.00	1,965.50
EKG/ECG	1,166.50	145.75	MRI SERVICES	0.00	0.00
IV THERAPY	2,812.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	25,101.50	14,444.50	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	9,574.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	5,909.25	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,361.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,256.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,650.75	1,788.93
RADIOLOGY THERAPEUTIC	604.75	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	1,540.26	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	5,120.00	IMPL DEV CHARGE PATIENTS	0.00	2,288.25
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,784.50	535.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	733.25			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	6,815.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,154.09	650.00			
			TOTAL ANCILLARY	133,756.27	55,621.18
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	133,756.27	55,621.18

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

Run Date: 08/24/2017
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ST. FRANCIS HEALTH, LLC
2122 MANCHESTER EXPY
COLUMBUS,GA 31904-6878

PROVIDER NUMBER 000001768A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	575,567.47	ADJUSTMENTS	1,176.68
COVERED CHARGES	539,125.97	CONTRACTUAL ALLOW	510,204.99
NON-COVERD CHARGES	36,441.50	TOTAL MEDICAID LIAB	28,920.98
		LESS: COB	22.85
		LESS: COPAYMENT	1,226.03
		REIMBURSEMENT	27,672.10
		TOTAL NUMBER OF CLAIMS	517

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

ST. FRANCIS HEALTH, LLC
 2122 MANCHESTER EXPY
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,010.50	100.00	OTHER LAB	627.00	0.00
MED/SURG SUPPLY	23,872.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	39,233.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	65,237.00	11,896.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	126,448.75	10,936.00
EKG/ECG	12,743.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	12,111.00	27.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,842.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,150.50	63.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,623.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	217,932.00	12,464.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,078.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,510.00	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	582.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,594.75	754.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	528.47	0.00			
			TOTAL ANCILLARY	539,125.97	36,441.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	539,125.97	36,441.50

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

ST. FRANCIS HEALTH, LLC
2122 MANCHESTER EXPY
COLUMBUS,GA 31904-6878

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,325.95	ADJUSTMENTS	0.00
COVERED CHARGES	10,325.95	CONTRACTUAL ALLOW	6,206.89
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	4,119.06
		LESS: COB	4,095.06
		LESS: COPAYMENT	24.00
		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

Run Date: 08/24/2017
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SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ST. FRANCIS HEALTH, LLC
 2122 MANCHESTER EXPY
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	431.95	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	321.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,477.25	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	2,773.25	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	462.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,666.25	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	193.50	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	10,325.95	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,325.95	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

ST. FRANCIS HEALTH, LLC
2122 MANCHESTER EXPY
COLUMBUS,GA 31904-6878

PROVIDER NUMBER
000001768A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,419,477.11	ADJUSTMENTS	43,931.48
COVERED CHARGES	1,350,106.58	CONTRACTUAL ALLOW	1,185,239.78
NON-COVERD CHARGES	69,370.53	TOTAL MEDICAID LIAB	164,866.80
		LESS: COB	0.00
		LESS: COPAYMENT	153.00
		REIMBURSEMENT	164,713.80

TOTAL NUMBER OF CLAIMS 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

ST. FRANCIS HEALTH, LLC
 2122 MANCHESTER EXPY
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	357,897.86	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	116,035.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,545.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	295.28	FEE SCHEDULE LAB	19,378.00	0.00
EKG/ECG	1,458.00	991.50	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	441,371.75	48,625.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	505.25	80.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	39,342.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,104.00	113.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,356.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,090.00	200.00
RADIOLOGY THERAPEUTIC	2,022.50	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	532.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	265,647.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	445.50	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	73,851.25	19,065.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,524.72	0.00			
			TOTAL ANCILLARY	1,350,106.58	69,370.53
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,350,106.58	69,370.53

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: 08/24/2017
Run Time: 04:11:03
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST. FRANCIS HEALTH, LLC
2122 MANCHESTER EXPY
COLUMBUS,GA 31904-6878

PROVIDER NUMBER
000001768A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/16	THROUGH	12/31/16
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: 08/24/2017
 Run Time: 04:17:13
 Page: 1

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,689,188.05	ADJUSTMENTS	65,579.33
COVERED CHARGES	3,625,074.89	CONTRACTUAL ALLOW	2,916,117.85
NON-COVERD CHARGES	64,113.16	TOTAL MEDICAID LIAB	708,957.04
		LESS: COB	1,527.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	707,429.95

TOTAL NUMBER OF ADMISSIONS 99

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	237		0	366,964.00		40,220.97
ROUTINE NURSERY	30		0	32,786.45		4,568.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	267		0	399,750.45		44,788.97
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	63		0	166,504.50		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	63		0	166,504.50		0.00
TOTAL ACCOMODATIONS	330		0	566,254.95		44,788.97

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	452,972.63	0.00	OTHER LAB	9,872.51	0.00
MED/SURG SUPPLY	570,655.09	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	235,500.44	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	70,516.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	79,469.79	1,154.26	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	50,003.52	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	10,627.94	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	23,414.05	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	435,356.31	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	79,494.96	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	129,280.26	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	197,703.44	0.00	AMBULANCE	0.00	0.00
GI SERVICES	44,131.51	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	208,299.66	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	93,687.91	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	14,968.36	0.00	INJECTABLE DRUGS	2,487.69	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	39,985.28	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	8,510.54	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	15,914.87	2,526.17	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,904.60	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	94,216.81	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,431.93
OTHER IMAGING SERVICE	11,214.67	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	51,972.01	9,873.12			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,096.59	3,338.71			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	48,541.64	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	71,020.61	0.00			
			TOTAL ANCILLARY	3,058,819.94	19,324.19
			TOTAL ACCOMODATIONS	566,254.95	44,788.97
			TOTAL CHARGES	3,625,074.89	64,113.16

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2216176017418	05/17/16 - 05/20/16	06/27/16	0.00	2,431.93	0.00	0.00	0.00
TOTAL				0.00	2,431.93	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	10/01/15	THROUGH	09/30/16
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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,041,560.89	ADJUSTMENTS	195,362.10
COVERED CHARGES	5,648,537.22	CONTRACTUAL ALLOW	4,856,283.55
NON-COVERD CHARGES	393,023.67	TOTAL MEDICAID LIAB	792,253.67
		LESS: COB	7,963.40
		LESS: COPAYMENT	1,596.00
		REIMBURSEMENT	782,694.27
		ALL OTHER	705,561.58
		FEE SCHEDULE-LAB	70,953.60
		INJECTABLE DRUGS	6,179.09

TOTAL NUMBER OF CLAIMS 2,013

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

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	132,198.69	19,479.89	OTHER LAB	234,820.22	0.00
MED/SURG SUPPLY	76,732.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	330.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	158,546.63	342.86	OTHER THERAPEUTIC SVC	0.00	5,667.87
CT SCAN	320,091.59	80,076.52	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,499.32	FEE SCHEDULE LAB	670,784.09	35,557.26
EKG/ECG	48,463.36	283.11	MRI SERVICES	15,877.58	0.00
IV THERAPY	417,105.06	4,305.79	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	643,832.56	33,200.08	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	549.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	14,962.20	9,496.33	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	376,274.48	0.00	AMBULANCE	0.00	0.00
GI SERVICES	233,346.86	31,920.37	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,550,115.30	1,558.41	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	277,481.83	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	90.30	INJECTABLE DRUGS	102,594.83	30,595.68
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	15,413.54	2,080.54	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	71,325.27
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	3,717.93
OTHER IMAGING SERVICE	103,365.22	27,590.60			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,815.92	7,928.41			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	17,703.65	6,630.81			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	47,120.49	11,277.76			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	176,341.62	8,068.56			
			TOTAL ANCILLARY	5,648,537.22	393,023.67
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,648,537.22	393,023.67

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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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016019060935	01/14/16 - 01/14/16	01/25/16	0.00	3,717.93	0.00	0.00	0.00
TOTAL				0.00	3,717.93	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

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	153,910.17	ADJUSTMENTS	0.00
COVERED CHARGES	116,476.09	CONTRACTUAL ALLOW	83,442.52
NON-COVERD CHARGES	37,434.08	TOTAL MEDICAID LIAB	33,033.57
		LESS: COB	32,991.59
		LESS: COPAYMENT	41.98
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 40

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,489.60	400.25	OTHER LAB	1,202.11	0.00
MED/SURG SUPPLY	3,647.15	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,902.14	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	760.38	FEE SCHEDULE LAB	20,636.39	1,416.20
EKG/ECG	1,116.16	283.11	MRI SERVICES	0.00	0.00
IV THERAPY	6,073.26	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,944.32	21,671.81	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	35.38	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,910.84	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,999.64	4,911.08	CAST ROOM	0.00	0.00
EMERGENCY ROOM	30,186.38	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,058.64	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,463.95	1,105.03
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	540.09	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	671.36	1,801.52			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,971.64	2,265.26			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	2,819.44			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,627.04	0.00			
			TOTAL ANCILLARY	116,476.09	37,434.08
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	116,476.09	37,434.08

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

Run Date: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	188,039.70	ADJUSTMENTS	161.82
COVERED CHARGES	185,310.99	CONTRACTUAL ALLOW	175,689.31
NON-COVERD CHARGES	2,728.71	TOTAL MEDICAID LIAB	9,621.68
		LESS: COB	35.00
		LESS: COPAYMENT	277.71
		REIMBURSEMENT	9,308.97
		TOTAL NUMBER OF CLAIMS	172

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,381.25	223.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	165.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,682.73	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,706.75	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,858.52	818.52
EKG/ECG	549.94	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	12,543.49	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	138,298.39	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,106.64	412.56
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	174.20	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,183.28	935.43			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	185,310.99	2,728.71
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	185,310.99	2,728.71

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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,692.04	ADJUSTMENTS	0.00
COVERED CHARGES	4,692.04	CONTRACTUAL ALLOW	2,869.17
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1,822.87
		LESS: COB	1,819.87
		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

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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 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	750.76	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,281.19	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	660.09	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,692.04	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,692.04	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

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	35,455.84	ADJUSTMENTS	0.00
COVERED CHARGES	33,863.02	CONTRACTUAL ALLOW	28,389.37
NON-COVERD CHARGES	1,592.82	TOTAL MEDICAID LIAB	5,473.65
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,473.65

TOTAL NUMBER OF CLAIMS 1

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	144.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,309.71	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	354.38	0.00
EKG/ECG	283.11	283.11	MRI SERVICES	0.00	0.00
IV THERAPY	1,061.68	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	3,343.10	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	28,676.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	33,863.02	1,592.82
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	33,863.02	1,592.82

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

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	10/01/15	THROUGH	09/30/16
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

ST JOSEPH'S HOSPITAL SAVANNAH
 11705 MERCY BLVD
 SAVANNAH,GA 31419-1711

PROVIDER NUMBER 000001801A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,435,784.28	ADJUSTMENTS	2,051,310.14
COVERED CHARGES	25,208,892.28	CONTRACTUAL ALLOW	19,352,846.09
NON-COVERD CHARGES	226,892.00	TOTAL MEDICAID LIAB	5,856,046.19
		LESS: COB	85,384.76
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,770,661.43

TOTAL NUMBER OF ADMISSIONS 367

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	870		0	759,775.00		3,094.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	870		0	759,775.00		3,094.00
SPECIAL CARE SERVICES						
CCU	237		0	752,482.00		0.00
ICU	1,811		0	3,178,525.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,048		0	3,931,007.00		0.00
TOTAL ACCOMODATIONS	2,918		0	4,690,782.00		3,094.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,267,525.00	1,083.00	OTHER LAB	110,231.00	0.00
MED/SURG SUPPLY	1,101,189.00	6,466.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,820,879.00	30,263.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	607,661.00	0.00	OTHER THERAPEUTIC SVC	0.00	43,570.00
CT SCAN	783,918.00	46,084.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	226,793.17	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	63,011.00	0.00	MRI SERVICES	312,691.00	0.00
IV THERAPY	269,081.00	2,485.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,323,742.00	12,372.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,701,942.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	462,324.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	66,666.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	308,807.00	2,991.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	206,442.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	45,676.00	0.00	INJECTABLE DRUGS	2,365,029.00	0.00
RADIOLOGY THERAPEUTIC	95,985.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	77,632.08	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	150,292.03	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	146,938.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,491,573.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	67,329.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	351,595.00	19,382.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	94,414.00	59,102.00			
AUDIOLOGY	3,399.00	0.00			
CARDIOLOGY	916,754.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	39,506.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	39,086.00	0.00			
			TOTAL ANCILLARY	20,518,110.28	223,798.00
			TOTAL ACCOMODATIONS	4,690,782.00	3,094.00
			TOTAL CHARGES	25,208,892.28	226,892.00

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

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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
Run Time: 04:11:15
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,761,506.90	ADJUSTMENTS	56,598.93
COVERED CHARGES	6,900,369.94	CONTRACTUAL ALLOW	5,848,169.78
NON-COVERD CHARGES	861,136.96	TOTAL MEDICAID LIAB	1,052,200.16
		LESS: COB	2,801.12
		LESS: COPAYMENT	2,538.00
		REIMBURSEMENT	1,046,861.04
		ALL OTHER	975,491.99
		FEE SCHEDULE-LAB	71,044.11
		INJECTABLE DRUGS	324.94
		TOTAL NUMBER OF CLAIMS	2,391

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	487,276.00	892.00	OTHER LAB	52,659.00	0.00
MED/SURG SUPPLY	195,187.00	19,181.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	426,178.00	13,978.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	805,962.00	120,485.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	28,376.00	12,671.03	FEE SCHEDULE LAB	636,017.34	53,218.00
EKG/ECG	56,471.00	2,682.00	MRI SERVICES	99,001.00	32,806.00
IV THERAPY	489,348.00	18,171.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,001,969.60	238,429.40	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	93,883.00	673.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	248,206.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	58,672.00	1,544.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,134,908.00	3,227.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	120,202.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,433.00	1,039.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	16,908.00	5,063.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	810.00	4,578.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	10,215.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	123,347.00	91,151.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	107,991.00	37,327.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,247.00	333.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	127,104.00	120,879.00			
AUDIOLOGY	114,237.00	15,290.00			
CARDIOLOGY	381,725.00	54,405.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,597.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	73,655.00	2,899.00			
			TOTAL ANCILLARY	6,900,369.94	861,136.96
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,900,369.94	861,136.96

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	147,034.00	ADJUSTMENTS	0.00
COVERED CHARGES	101,741.33	CONTRACTUAL ALLOW	68,441.91
NON-COVERD CHARGES	45,292.67	TOTAL MEDICAID LIAB	33,299.42
		LESS: COB	33,280.64
		LESS: COPAYMENT	18.78
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 39

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,628.00	0.00	OTHER LAB	1,101.00	0.00
MED/SURG SUPPLY	1,007.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,721.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,191.00	17,052.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	15,089.00	574.00
EKG/ECG	745.00	0.00	MRI SERVICES	0.00	2,273.00
IV THERAPY	12,185.00	314.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,170.33	8,555.67	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	181.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,512.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	3,088.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,204.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,848.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,185.00	1,403.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	5,608.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,088.00	2,803.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,642.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	3,622.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,244.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	101,741.33	45,292.67
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	101,741.33	45,292.67

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: 08/24/2017
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Page: 8

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	367,661.00	ADJUSTMENTS	161.82
COVERED CHARGES	345,716.00	CONTRACTUAL ALLOW	334,248.30
NON-COVERD CHARGES	21,945.00	TOTAL MEDICAID LIAB	11,467.70
		LESS: COB	0.00
		LESS: COPAYMENT	480.00
		REIMBURSEMENT	10,987.70
		TOTAL NUMBER OF CLAIMS	205

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,247.00	53.00	OTHER LAB	5,440.00	0.00
MED/SURG SUPPLY	284.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,708.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	30,236.00	11,604.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	44,284.00	3,149.00
EKG/ECG	3,278.00	0.00	MRI SERVICES	35,511.00	0.00
IV THERAPY	44,486.00	1,845.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,233.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	129,773.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,169.00	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	9,067.00	5,294.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	345,716.00	21,945.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	345,716.00	21,945.00

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: 08/24/2017
Run Time: 04:11:35
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,543.00	ADJUSTMENTS	0.00
COVERED CHARGES	10,159.00	CONTRACTUAL ALLOW	8,272.42
NON-COVERD CHARGES	1,384.00	TOTAL MEDICAID LIAB	1,886.58
		LESS: COB	1,871.58
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	7

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 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	506.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	891.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,448.00	422.00
EKG/ECG	149.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	628.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,525.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	415.00	60.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,597.00	902.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	10,159.00	1,384.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,159.00	1,384.00

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 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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,609,616.02	ADJUSTMENTS	77,593.77
COVERED CHARGES	1,395,013.67	CONTRACTUAL ALLOW	1,273,957.31
NON-COVERD CHARGES	214,602.35	TOTAL MEDICAID LIAB	121,056.36
		LESS: COB	0.00
		LESS: COPAYMENT	121.55
		REIMBURSEMENT	120,934.81
		TOTAL NUMBER OF CLAIMS	22

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	77,022.00	424.00	OTHER LAB	1,066.00	0.00
MED/SURG SUPPLY	284,125.00	450.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,988.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,832.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,148.00	FEE SCHEDULE LAB	23,933.00	16.00
EKG/ECG	894.00	447.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	108,749.02	9,800.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	543.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	73,990.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	28,794.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	318.00	53.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	328.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	495,318.00	136,202.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,352.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	275,166.65	65,433.35			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,923.00	301.00			
			TOTAL ANCILLARY	1,395,013.67	214,602.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,395,013.67	214,602.35

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: 08/24/2017
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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	07/01/15	THROUGH	06/30/16
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

SAINT JOSEPH'S HOSPITAL OF ATLANTA
 5665 PEACHTREE DUNWOODY RD NE
 ATLANTA,GA 30342-1701

PROVIDER NUMBER 000001812A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,979,659.45	ADJUSTMENTS	1,435,714.29
COVERED CHARGES	22,188,480.52	CONTRACTUAL ALLOW	14,601,715.06
NON-COVERD CHARGES	791,178.93	TOTAL MEDICAID LIAB	7,586,765.46
		LESS: COB	246,264.75
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,340,500.71

TOTAL NUMBER OF ADMISSIONS 503

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,464		0	3,298,050.00		210,444.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,464		0	3,298,050.00		210,444.00
SPECIAL CARE SERVICES						
CCU	182		0	887,250.00		0.00
ICU	652		0	2,338,340.00		43,875.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	834		0	3,225,590.00		43,875.00
TOTAL ACCOMODATIONS	3,298		0	6,523,640.00		254,319.00

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

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

Run Date: 08/24/2017
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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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	833,372.65	16,245.79	OTHER LAB	148,201.00	1,048.00
MED/SURG SUPPLY	750,158.32	47,719.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,695,383.00	30,244.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	406,244.00	9,687.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,155,834.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	177,096.31	7,383.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	86,666.00	0.00	MRI SERVICES	514,935.00	0.00
IV THERAPY	320.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,147,930.00	8,455.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	744,573.00	10,524.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	380,210.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	180,277.00	6,006.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	602,429.00	1,992.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	141,125.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	100,576.22
LABORATORY PATHOLOGIC	136,546.00	0.00	INJECTABLE DRUGS	2,052,224.04	24,320.86
RADIOLOGY THERAPEUTIC	10,960.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	90,736.45	3,397.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	124,137.60	2,833.06	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	257,372.00	25,438.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	616.00	3,456.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	766,747.15	850.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	208,135.00
OTHER IMAGING SERVICE	89,718.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	211,644.00	11,149.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	134,136.00	16,331.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	798,960.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	8,460.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	17,829.00	1,070.00			
			TOTAL ANCILLARY	15,664,840.52	536,859.93
			TOTAL ACCOMODATIONS	6,523,640.00	254,319.00
			TOTAL CHARGES	22,188,480.52	791,178.93

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2315322000048	09/21/15 - 09/24/15	12/28/15	0.00	13,920.00	0.00	1,476.11	0.00
614	2315342000022	10/12/15 - 10/20/15	01/11/16	0.00	6,960.00	0.00	2,517.47	0.00
615	2015351090691	10/17/15 - 10/23/15	12/21/15	0.00	9,401.00	0.00	0.00	0.00
615	2015358057024	11/10/15 - 11/12/15	12/28/15	0.00	12,440.00	0.00	0.00	0.00
615	5215362019631	09/13/15 - 09/21/15	02/22/16	0.00	9,401.00	0.00	0.00	0.00
615	2316004000167	11/16/15 - 11/20/15	02/01/16	0.00	9,401.00	0.00	2,052.78	0.00
614	2316067000065	12/07/15 - 12/18/15	04/18/16	0.00	6,960.00	0.00	3,898.76	0.00
615	9816070001766	09/06/15 - 09/10/15	03/14/16	0.00	12,440.00	0.00	1,724.51	0.00
615	2316110000064	12/27/15 - 12/29/15	05/30/16	0.00	9,401.00	0.00	3,472.18	0.00
615	2016119090809	04/10/16 - 04/23/16	05/02/16	0.00	9,401.00	0.00	0.00	0.00
615	2016122000855	04/21/16 - 04/25/16	05/09/16	0.00	3,181.00	0.00	0.00	0.00
614	2316126000016	02/22/16 - 03/03/16	06/13/16	0.00	6,960.00	0.00	2,048.99	0.00
615	2016183077665	03/30/16 - 04/05/16	07/11/16	0.00	9,401.00	0.00	0.00	0.00
615	2016231098303	06/04/16 - 06/24/16	08/22/16	0.00	3,181.00	0.00	0.00	0.00
614	2316239000032	03/09/16 - 03/16/16	10/03/16	0.00	6,960.00	0.00	3,545.26	0.00
615	2016250065612	08/19/16 - 08/29/16	09/12/16	0.00	12,440.00	0.00	0.00	0.00
614	2316251000071	02/01/16 - 02/23/16	10/10/16	0.00	3,138.00	0.00	2,679.59	0.00
614	2316278000191	11/17/15 - 11/20/15	11/07/16	0.00	6,960.00	0.00	1,063.11	0.00
615	2216298008283	10/28/15 - 11/09/15	10/31/16	0.00	12,440.00	0.00	0.00	0.00
614	2016319030538	08/12/16 - 08/22/16	11/21/16	0.00	6,960.00	0.00	0.00	0.00
615	5217032000326	07/15/16 - 07/25/16	02/06/17	0.00	12,440.00	0.00	0.00	0.00
615	2317040000242	08/14/16 - 08/16/16	02/27/17	0.00	9,401.00	0.00	0.00	0.00
615	2317103000353	05/07/16 - 05/11/16	05/01/17	0.00	9,401.00	0.00	0.00	0.00
615	2217156007570	07/24/16 - 08/19/16	06/12/17	0.00	3,181.00	0.00	0.00	0.00
614	2017216081616	10/01/15 - 10/14/15	08/14/17	0.00	2,366.00	0.00	0.00	0.00
TOTAL				0.00	208,135.00	0.00	24,478.76	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

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	166,577.88	ADJUSTMENTS	0.00
COVERED CHARGES	166,577.88	CONTRACTUAL ALLOW	101,084.31
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	65,493.57
		LESS: COB	65,493.57
		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	5		0	7,125.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5		0	7,125.00		0.00
SPECIAL CARE SERVICES						
CCU	4		0	19,500.00		0.00
ICU	1		0	2,180.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	21,680.00		0.00
TOTAL ACCOMODATIONS	10		0	28,805.00		0.00

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	236.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,971.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,862.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,274.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,512.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	392.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,606.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,440.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,259.61	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	454.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	657.02	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,748.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	665.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	72.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	92,624.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	137,772.88	0.00
			TOTAL ACCOMODATIONS	28,805.00	0.00
			TOTAL CHARGES	166,577.88	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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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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,598,257.48	ADJUSTMENTS	74,015.20
COVERED CHARGES	3,740,598.10	CONTRACTUAL ALLOW	3,057,929.03
NON-COVERD CHARGES	1,857,659.38	TOTAL MEDICAID LIAB	682,669.07
		LESS: COB	631.43
		LESS: COPAYMENT	1,933.26
		REIMBURSEMENT	680,104.38
		ALL OTHER	622,441.51
		FEE SCHEDULE-LAB	47,726.83
		INJECTABLE DRUGS	9,936.04
		TOTAL NUMBER OF CLAIMS	1,399

SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

SAINT JOSEPH'S HOSPITAL OF ATLANTA
 5665 PEACHTREE DUNWOODY RD NE
 ATLANTA,GA 30342-1701

PROVIDER NUMBER
 000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,936.84	49,011.07	OTHER LAB	69,630.00	1,637.00
MED/SURG SUPPLY	97,934.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	14.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	207,628.00	27,414.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	434,976.00	394,048.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,934.00	FEE SCHEDULE LAB	411,640.50	13,542.00
EKG/ECG	42,778.00	2,044.00	MRI SERVICES	313,312.00	305,849.00
IV THERAPY	1,440.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	340,281.00	108,726.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	16,220.00	5,160.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	62,917.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	29,741.00	33,470.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	738,691.00	8,650.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	58,895.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	151,804.82	77,697.17
RADIOLOGY THERAPEUTIC	91,614.00	183,294.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,461.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	3,551.14	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	9,851.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	22,810.00	358.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	32,746.80	237,713.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	75,806.00
OTHER IMAGING SERVICE	125,885.00	63,130.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,340.00	3,670.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	29,022.00	92,906.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	302,501.00	154,125.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	705.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	129,149.14	598.00			
			TOTAL ANCILLARY	3,740,598.10	1,857,659.38
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,740,598.10	1,857,659.38

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

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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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015257034458	09/03/15 - 09/03/15	09/21/15	0.00	6,220.00	0.00	0.00	0.00
615	2015257034458	09/03/15 - 09/03/15	09/21/15	0.00	6,220.00	0.00	0.00	0.00
615	2016005048926	12/20/15 - 12/20/15	01/11/16	0.00	3,181.00	0.00	0.00	0.00
615	2016005048926	12/20/15 - 12/20/15	01/11/16	0.00	3,181.00	0.00	0.00	0.00
615	5916148000604	03/08/16 - 03/08/16	05/30/16	0.00	6,220.00	0.00	0.00	0.00
615	5916148000604	03/08/16 - 03/08/16	05/30/16	0.00	6,220.00	0.00	0.00	0.00
615	5916148001354	02/13/16 - 02/13/16	05/30/16	0.00	3,181.00	0.00	0.00	0.00
615	5916148001354	02/13/16 - 02/13/16	05/30/16	0.00	6,220.00	0.00	0.00	0.00
615	2316159000138	12/21/15 - 12/21/15	06/20/16	0.00	3,181.00	0.00	0.00	0.00
615	2316159000138	12/21/15 - 12/21/15	06/20/16	0.00	6,220.00	0.00	0.00	0.00
615	2016194000378	07/05/16 - 07/05/16	07/18/16	0.00	3,181.00	0.00	0.00	0.00
615	2016194000378	07/05/16 - 07/05/16	07/18/16	0.00	6,220.00	0.00	0.00	0.00
615	2216250003360	12/19/15 - 12/19/15	09/12/16	0.00	3,181.00	0.00	0.00	0.00
615	2216250003360	12/19/15 - 12/19/15	09/12/16	0.00	6,220.00	0.00	0.00	0.00
614	2317033000114	03/18/16 - 03/18/16	02/20/17	0.00	6,960.00	0.00	0.00	0.00
TOTAL				0.00	75,806.00	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

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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	257,065.84	ADJUSTMENTS	0.00
COVERED CHARGES	98,147.45	CONTRACTUAL ALLOW	9,391.10
NON-COVERD CHARGES	158,918.39	TOTAL MEDICAID LIAB	88,756.35
		LESS: COB	88,717.05
		LESS: COPAYMENT	39.30
		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

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	481.65	6,101.01	OTHER LAB	948.00	0.00
MED/SURG SUPPLY	5,800.68	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,619.00	4,206.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,222.00	12,518.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,422.00	276.00
EKG/ECG	1,314.00	292.00	MRI SERVICES	0.00	46,257.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,822.00	22,922.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	324.00	612.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,032.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,307.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,047.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,617.12	1,930.38
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,710.00	16,259.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	18,802.00
OTHER IMAGING SERVICE	1,161.00	8,774.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	715.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	28,056.00	19,254.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,264.00	0.00			
			TOTAL ANCILLARY	98,147.45	158,918.39
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	98,147.45	158,918.39

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

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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016239082941	01/26/16 - 01/26/16	09/05/16	0.00	6,220.00	0.00	4,484.97	0.00
615	2016239082941	01/26/16 - 01/26/16	09/05/16	0.00	3,181.00	0.00	4,484.97	0.00
615	2016306072765	04/29/16 - 04/29/16	11/07/16	0.00	3,181.00	0.00	2,704.68	0.00
615	2016306072765	04/29/16 - 04/29/16	11/07/16	0.00	6,220.00	0.00	2,704.68	0.00
TOTAL				0.00	18,802.00	0.00	14,379.30	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: 08/24/2017
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Page: 12

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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	91,464.18	ADJUSTMENTS	0.00
COVERED CHARGES	56,984.22	CONTRACTUAL ALLOW	54,299.10
NON-COVERD CHARGES	34,479.96	TOTAL MEDICAID LIAB	2,685.12
		LESS: COB	0.00
		LESS: COPAYMENT	135.75
		REIMBURSEMENT	2,549.37
		TOTAL NUMBER OF CLAIMS	48

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	600.00	323.06	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	235.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,973.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	12,579.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,129.00	614.00
EKG/ECG	730.00	0.00	MRI SERVICES	0.00	6,804.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	336.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	33,605.00	1,134.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,061.22	220.90
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	9,401.00
OTHER IMAGING SERVICE	0.00	740.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,482.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,315.00	1,182.00			
			TOTAL ANCILLARY	56,984.22	34,479.96
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	56,984.22	34,479.96

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: 08/24/2017
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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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2317109000132	06/16/16 - 06/17/16	04/24/17	0.00	3,181.00	0.00	0.00	0.00
615	2317109000132	06/16/16 - 06/17/16	04/24/17	0.00	6,220.00	0.00	0.00	0.00
TOTAL				0.00	9,401.00	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

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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,540.52	ADJUSTMENTS	0.00
COVERED CHARGES	3,620.90	CONTRACTUAL ALLOW	2,286.20
NON-COVERD CHARGES	4,919.62	TOTAL MEDICAID LIAB	1,334.70
		LESS: COB	1,328.70
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 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	33.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	251.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	4,735.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	302.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,933.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,101.90	184.62
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,620.90	4,919.62
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,620.90	4,919.62

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

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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	176,119.89	ADJUSTMENTS	17,508.69
COVERED CHARGES	163,467.59	CONTRACTUAL ALLOW	140,110.67
NON-COVERD CHARGES	12,652.30	TOTAL MEDICAID LIAB	23,356.92
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	23,341.92

TOTAL NUMBER OF CLAIMS 4

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,096.41	1,615.27	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,408.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,962.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,046.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,002.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	59,382.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,348.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,141.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,140.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,434.18	504.03
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	34,650.00	8,438.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	26,794.00	2,095.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,064.00	0.00			
			TOTAL ANCILLARY	163,467.59	12,652.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	163,467.59	12,652.30

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: 08/24/2017
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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	09/01/15	THROUGH	08/31/16
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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,164,223.47	ADJUSTMENTS	1,087,634.61
COVERED CHARGES	16,747,429.21	CONTRACTUAL ALLOW	11,789,385.00
NON-COVERD CHARGES	1,416,794.26	TOTAL MEDICAID LIAB	4,958,044.21
		LESS: COB	204,787.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,753,256.71

TOTAL NUMBER OF ADMISSIONS 549

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,495		0	1,432,798.00		248,330.00
ROUTINE NURSERY	390		0	398,155.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,885		0	1,830,953.00		248,330.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	947		0	1,966,900.00		0.00
NICU	5		0	11,240.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		361	0.00		399,686.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	952		361	1,978,140.00		399,686.00
TOTAL ACCOMODATIONS	2,837		361	3,809,093.00		648,016.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,462,608.20	24,226.26	OTHER LAB	110,250.00	0.00
MED/SURG SUPPLY	558,481.50	6,297.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	918,569.00	2,063.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	326,496.00	0.00	OTHER THERAPEUTIC SVC	0.00	162.00
CT SCAN	0.00	586,500.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	255,979.00	7,607.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	112,835.00	0.00	MRI SERVICES	203,573.00	0.00
IV THERAPY	234,840.00	738.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,618,972.00	7,294.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	291,515.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	999,501.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	418,697.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	82,040.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	587,745.00	152.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	303,472.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	61,227.00	55.00	INJECTABLE DRUGS	15,739.15	0.00
RADIOLOGY THERAPEUTIC	3,872.36	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	196,409.00	7,418.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	100,567.00	3,007.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	138,600.00	3,600.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	102.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	843,919.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	103,546.00
OTHER IMAGING SERVICE	129,542.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	100,018.00	10,000.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	21,218.00	5,280.00			
AUDIOLOGY	10,788.00	0.00			
CARDIOLOGY	811,041.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	17,944.00	833.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,776.00	0.00			
			TOTAL ANCILLARY	12,938,336.21	768,778.26
			TOTAL ACCOMODATIONS	3,809,093.00	648,016.00
			TOTAL CHARGES	16,747,429.21	1,416,794.26

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015316006119	10/22/15 - 10/27/15	11/16/15	0.00	3,558.00	0.00	0.00	0.00
615	2015322081215	08/03/15 - 08/04/15	11/23/15	0.00	4,300.00	0.00	0.00	0.00
614	2015356008757	11/13/15 - 11/16/15	12/28/15	0.00	2,383.00	0.00	0.00	0.00
614	2015358003836	12/06/15 - 12/10/15	12/28/15	0.00	2,591.00	0.00	0.00	0.00
615	2015360000481	11/30/15 - 12/18/15	01/04/16	0.00	2,156.00	0.00	0.00	0.00
618	5215362011327	08/04/15 - 08/07/15	02/22/16	0.00	1,862.00	0.00	0.00	0.00
614	5215362016070	08/17/15 - 08/28/15	02/22/16	0.00	3,558.00	0.00	0.00	0.00
614	5215362022991	09/22/15 - 09/29/15	02/22/16	0.00	2,386.00	0.00	0.00	0.00
615	5215363002602	07/15/15 - 07/17/15	02/22/16	0.00	2,156.00	0.00	0.00	0.00
615	5215363003704	09/28/15 - 10/12/15	02/22/16	0.00	2,156.00	0.00	0.00	0.00
615	2316006000133	11/13/15 - 11/20/15	02/08/16	0.00	2,156.00	0.00	2,284.29	0.00
614	2016008012029	12/12/15 - 12/23/15	01/11/16	0.00	2,910.00	0.00	0.00	0.00
615	2016008012071	12/12/15 - 12/15/15	01/11/16	0.00	2,156.00	0.00	0.00	0.00
614	2016009003260	12/01/15 - 12/07/15	01/18/16	0.00	2,355.00	0.00	0.00	0.00
615	2216018003509	12/04/15 - 01/01/16	01/25/16	0.00	2,156.00	0.00	0.00	0.00
614	2216025002070	11/29/15 - 12/17/15	02/01/16	0.00	2,617.00	0.00	0.00	0.00
615	2216025002070	11/29/15 - 12/17/15	02/01/16	0.00	2,156.00	0.00	0.00	0.00
614	2016025034138	01/06/16 - 01/13/16	02/01/16	0.00	2,355.00	0.00	0.00	0.00
614	2216032002168	12/12/15 - 12/22/15	02/08/16	0.00	3,728.00	0.00	0.00	0.00
614	2016070002705	02/09/16 - 02/19/16	03/14/16	0.00	2,910.00	0.00	0.00	0.00
614	2216075004421	10/12/15 - 10/29/15	03/21/16	0.00	3,310.00	0.00	0.00	0.00
614	2016098006881	03/18/16 - 03/23/16	04/11/16	0.00	2,591.00	0.00	0.00	0.00
614	9816099000018	12/23/15 - 01/02/16	04/18/16	0.00	1,415.00	0.00	0.00	0.00
615	2016126003484	04/13/16 - 04/16/16	05/09/16	0.00	2,156.00	0.00	0.00	0.00
614	2016126003648	04/16/16 - 04/19/16	05/09/16	0.00	2,910.00	0.00	0.00	0.00
614	2016132010886	10/20/15 - 10/23/15	05/23/16	0.00	1,415.00	0.00	0.00	0.00
615	2016147005595	05/11/16 - 05/13/16	05/30/16	0.00	2,156.00	0.00	0.00	0.00
614	2316161000001	04/26/16 - 05/04/16	07/11/16	0.00	2,383.00	0.00	576.59	0.00
614	2016162077680	12/17/15 - 12/23/15	06/20/16	0.00	1,415.00	0.00	0.00	0.00
614	2016169067623	05/21/16 - 05/25/16	06/27/16	0.00	3,650.00	0.00	0.00	0.00
615	2216179002170	06/02/16 - 06/08/16	07/04/16	0.00	2,156.00	0.00	0.00	0.00
614	2216189001476	03/11/16 - 03/21/16	07/11/16	0.00	2,591.00	0.00	0.00	0.00
615	2216200000200	06/20/16 - 06/22/16	07/25/16	0.00	2,156.00	0.00	0.00	0.00
614	2016201009168	06/26/16 - 07/05/16	07/25/16	0.00	2,355.00	0.00	0.00	0.00
615	2016204010608	02/20/16 - 02/23/16	07/25/16	0.00	5,942.00	0.00	0.00	0.00
614	2216259013899	07/09/15 - 07/27/15	09/19/16	0.00	3,728.00	0.00	0.00	0.00
615	2016300008818	04/20/16 - 04/23/16	10/31/16	0.00	2,156.00	0.00	0.00	0.00
615	2016323009050	02/11/16 - 02/29/16	11/21/16	0.00	4,300.00	0.00	0.00	0.00
615	2016340034588	10/08/15 - 10/10/15	12/12/16	0.00	2,156.00	0.00	0.00	0.00
TOTAL				0.00	103,546.00	0.00	2,860.88	0.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	390,063.63	ADJUSTMENTS	0.00
COVERED CHARGES	371,180.63	CONTRACTUAL ALLOW	155,358.20
NON-COVERD CHARGES	18,883.00	TOTAL MEDICAID LIAB	215,822.43
		LESS: COB	215,822.43
		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	52		0	52,104.00		14,212.00
ROUTINE NURSERY	105		0	119,614.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	157		0	171,718.00		14,212.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	5		0	11,240.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	11,240.00		0.00
TOTAL ACCOMODATIONS	162		0	182,958.00		14,212.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63,897.04	0.00	OTHER LAB	4,781.00	0.00
MED/SURG SUPPLY	4,130.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	25,362.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,744.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,515.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,812.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,520.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	45,492.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,956.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,360.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,391.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,559.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,040.00	0.00	INJECTABLE DRUGS	14,637.59	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	2,156.00
OTHER IMAGING SERVICE	2,534.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	186.00	0.00			
CARDIOLOGY	4,601.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,220.00	0.00			
			TOTAL ANCILLARY	188,222.63	4,671.00
			TOTAL ACCOMODATIONS	182,958.00	14,212.00
			TOTAL CHARGES	371,180.63	18,883.00

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

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	9716075981002	10/08/15 - 10/15/15	03/21/16	0.00	2,156.00	0.00	15,049.26	0.00
TOTAL				0.00	2,156.00	0.00	15,049.26	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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,686,520.12	ADJUSTMENTS	107,785.92
COVERED CHARGES	11,295,938.16	CONTRACTUAL ALLOW	8,790,143.54
NON-COVERD CHARGES	1,390,581.96	TOTAL MEDICAID LIAB	2,505,794.62
		LESS: COB	18,562.19
		LESS: COPAYMENT	4,480.06
		REIMBURSEMENT	2,482,752.37
		ALL OTHER	2,123,376.33
		FEE SCHEDULE-LAB	170,134.60
		INJECTABLE DRUGS	189,241.44

TOTAL NUMBER OF CLAIMS 5,036

SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

ST MARY'S HOSPITAL
 1230 BAXTER ST
 ATHENS,GA 30606-3712

PROVIDER NUMBER
 000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	276,606.03	3.90	OTHER LAB	101,544.00	888.00
MED/SURG SUPPLY	222,298.21	97,434.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	1,319.00	0.00
RADIOLOGY-DIAGNOSTIC	645,409.00	2,728.00	OTHER THERAPEUTIC SVC	0.00	6,038.00
CT SCAN	850,500.00	185,894.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	17,066.00	9,955.00	FEE SCHEDULE LAB	768,290.10	51,664.00
EKG/ECG	164,425.00	15,555.00	MRI SERVICES	414,144.00	66,666.00
IV THERAPY	718,360.00	13,028.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,435,735.58	189,894.42	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	81,148.00	10,365.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	524,022.00	2,915.00	AMBULANCE	0.00	0.00
GI SERVICES	191,647.00	46,466.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,082,967.50	5,224.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	614,533.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	3,977.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	924,580.74	259,607.14
RADIOLOGY THERAPEUTIC	14,283.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,703.00	8,335.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	448.00	15,185.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	110,231.00	4,406.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,663.00	103,384.00
LITHOTRIPSY	45,501.00	0.00	NO CC/INVALID REV CODE	0.00	18,414.00
OTHER IMAGING SERVICE	254,833.00	47,113.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,678.00	13,161.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	168,594.00	59,443.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	443,040.00	150,595.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	116,283.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	79,086.00	2,243.00			
			TOTAL ANCILLARY	11,295,938.16	1,390,581.96
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,295,938.16	1,390,581.96

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5915301000997	09/25/15 - 09/25/15	11/02/15	0.00	2,156.00	0.00	0.00	0.00
615	5915321000827	09/29/15 - 09/29/15	11/23/15	0.00	2,156.00	0.00	0.00	0.00
615	2015344012158	10/28/15 - 10/28/15	12/14/15	0.00	2,156.00	0.00	0.00	0.00
615	2016016007897	12/05/15 - 12/05/15	01/25/16	0.00	3,322.00	0.00	0.00	0.00
615	2016022012361	12/13/15 - 12/13/15	01/25/16	0.00	2,156.00	0.00	0.00	0.00
615	2016061003846	02/03/16 - 02/03/16	03/07/16	0.00	2,156.00	0.00	0.00	0.00
615	2216326000634	06/13/16 - 06/13/16	11/28/16	0.00	2,156.00	0.00	0.00	0.00
615	2016341073975	09/28/15 - 09/28/15	12/12/16	0.00	2,156.00	0.00	0.00	0.00
TOTAL				0.00	18,414.00	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

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	236,129.17	ADJUSTMENTS	0.00
COVERED CHARGES	171,828.35	CONTRACTUAL ALLOW	83,519.57
NON-COVERD CHARGES	64,300.82	TOTAL MEDICAID LIAB	88,308.78
		LESS: COB	88,242.01
		LESS: COPAYMENT	66.77
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 115

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,448.16	0.00	OTHER LAB	2,144.00	0.00
MED/SURG SUPPLY	7,135.00	4,683.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,474.00	559.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,006.00	9,044.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,035.00	440.00	FEE SCHEDULE LAB	10,858.00	1,129.00
EKG/ECG	765.00	0.00	MRI SERVICES	3,977.00	3,798.00
IV THERAPY	9,733.00	278.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,838.00	7,090.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,640.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	32,576.00	559.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,361.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,824.19	4,518.82
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,892.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,987.00	102.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,437.00	11,668.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,502.00	2,900.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,634.00	3,618.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	25,138.00	12,022.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	798.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	518.00	0.00			
			TOTAL ANCILLARY	171,828.35	64,300.82
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	171,828.35	64,300.82

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

Run Date: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	926,322.43	ADJUSTMENTS	485.46
COVERED CHARGES	886,105.37	CONTRACTUAL ALLOW	843,479.09
NON-COVERD CHARGES	40,217.06	TOTAL MEDICAID LIAB	42,626.28
		LESS: COB	0.00
		LESS: COPAYMENT	1,483.19
		REIMBURSEMENT	41,143.09
		TOTAL NUMBER OF CLAIMS	762

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,856.03	2.60	OTHER LAB	2,664.00	0.00
MED/SURG SUPPLY	2,724.00	5,326.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	90,679.00	812.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	67,502.00	15,279.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	66,356.00	4,237.00
EKG/ECG	9,180.00	255.00	MRI SERVICES	2,655.00	0.00
IV THERAPY	85,541.00	1,761.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,540.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,268.00	324.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,425.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	447,717.00	1,056.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,795.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	38,620.34	6,010.46
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	102.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	23,255.00	5,052.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,328.00	0.00			
			TOTAL ANCILLARY	886,105.37	40,217.06
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	886,105.37	40,217.06

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 MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	42,778.21	ADJUSTMENTS	0.00
COVERED CHARGES	31,833.96	CONTRACTUAL ALLOW	23,061.48
NON-COVERD CHARGES	10,944.25	TOTAL MEDICAID LIAB	8,772.48
		LESS: COB	8,738.89
		LESS: COPAYMENT	33.59
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	18

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,495.86	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,110.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,006.00	2,515.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,488.00	80.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	2,801.00
IV THERAPY	5,002.00	520.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	3,535.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,045.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,856.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,051.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,682.10	198.25
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	802.00	1,295.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	296.00	0.00			
			TOTAL ANCILLARY	31,833.96	10,944.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	31,833.96	10,944.25

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,593,340.72	ADJUSTMENTS	21,747.40
COVERED CHARGES	1,842,488.26	CONTRACTUAL ALLOW	1,603,272.70
NON-COVERD CHARGES	750,852.46	TOTAL MEDICAID LIAB	239,215.56
		LESS: COB	0.00
		LESS: COPAYMENT	129.00
		REIMBURSEMENT	239,086.56

TOTAL NUMBER OF CLAIMS 44

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,009.87	0.00	OTHER LAB	1,067.00	0.00
MED/SURG SUPPLY	82,459.00	44,205.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,465.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,757.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,889.00	775.00
EKG/ECG	3,060.00	255.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,062.00	372.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,062,753.30	13,376.70	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,976.00	162.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	69,382.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	10,076.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,595.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	53,203.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	227,489.09	8,476.76
RADIOLOGY THERAPEUTIC	6,210.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	14,557.00	662,238.00
LITHOTRIPSY	30,334.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,323.00	1,535.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	183,175.00	9,381.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	18,722.00	0.00			
			TOTAL ANCILLARY	1,842,488.26	750,852.46
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,842,488.26	750,852.46

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: 08/24/2017
Run Time: 04:10:13
Page: 18

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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
 Run Time: 04:12:28
 Page: 1

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,826,560.97	ADJUSTMENTS	1,955.65
COVERED CHARGES	2,793,757.07	CONTRACTUAL ALLOW	1,777,860.97
NON-COVERD CHARGES	32,803.90	TOTAL MEDICAID LIAB	1,015,896.10
		LESS: COB	18,569.26
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	997,326.84

TOTAL NUMBER OF ADMISSIONS 150

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	306		0	185,130.00		16,290.00
ROUTINE NURSERY	44		0	21,560.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	350		0	206,690.00		16,290.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	274		0	344,500.00		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	274		0	344,500.00		0.00
TOTAL ACCOMODATIONS	624		0	551,190.00		16,290.00

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	399,257.73	0.00	OTHER LAB	18,509.70	0.00
MED/SURG SUPPLY	636,086.14	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	278,917.40	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	59,726.15	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	104,510.50	9,226.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	27,225.45	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	20,717.60	0.00	MRI SERVICES	9,520.15	0.00
IV THERAPY	15,220.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	112,540.85	4,200.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	42,868.70	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	218,006.35	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	38,565.05	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,504.50	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	61,181.35	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,211.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	4,948.10	0.00	INJECTABLE DRUGS	11,606.43	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,425.80	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,098.15	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	2,120.25	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	24,693.39	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,367.55	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,032.10	104.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	11,054.15	2,982.60			
AUDIOLOGY	1,620.35	0.00			
CARDIOLOGY	29,141.81	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	604.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	66,285.12	0.00			
			TOTAL ANCILLARY	2,242,567.07	16,513.90
			TOTAL ACCOMODATIONS	551,190.00	16,290.00
			TOTAL CHARGES	2,793,757.07	32,803.90

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,123.55	ADJUSTMENTS	0.00
COVERED CHARGES	6,748.85	CONTRACTUAL ALLOW	1,423.93
NON-COVERD CHARGES	374.70	TOTAL MEDICAID LIAB	5,324.92
		LESS: COB	5,324.92
		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	1,815.00		165.00
ROUTINE NURSERY	0		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	1,815.00		165.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	1,815.00		165.00

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,323.09	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	380.41	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	427.05	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,330.50	209.70	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	160.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	1,312.80	0.00			
			TOTAL ANCILLARY	4,933.85	209.70
			TOTAL ACCOMODATIONS	1,815.00	165.00
			TOTAL CHARGES	6,748.85	374.70

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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,467,805.95	ADJUSTMENTS	78,458.30
COVERED CHARGES	2,248,916.42	CONTRACTUAL ALLOW	1,346,260.71
NON-COVERD CHARGES	218,889.53	TOTAL MEDICAID LIAB	902,655.71
		LESS: COB	2,042.35
		LESS: COPAYMENT	2,251.16
		REIMBURSEMENT	898,362.20
		ALL OTHER	841,110.41
		FEE SCHEDULE-LAB	55,892.94
		INJECTABLE DRUGS	1,358.85

TOTAL NUMBER OF CLAIMS 1,860

STEPHENS COUNTY HOSPITAL
 163 HOSPITAL DR
 TOCCOA,GA 30577-6820

PROVIDER NUMBER
 000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	138,024.51	20,369.98	OTHER LAB	62,068.25	0.00
MED/SURG SUPPLY	270,022.89	640.55	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	122,050.35	4,387.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	252,579.45	32,129.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	43,088.60	6,331.65	FEE SCHEDULE LAB	321,268.30	12,634.75
EKG/ECG	32,839.60	2,424.40	MRI SERVICES	62,183.35	15,430.25
IV THERAPY	31,825.00	5,765.00	PROFESSIONAL FEES	0.00	70.00
OPERATING ROOM	97,691.17	21,316.33	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,600.67	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	14,247.50	13,294.85	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	38,101.90	0.00	AMBULANCE	0.00	0.00
GI SERVICES	26,347.53	3,835.93	CAST ROOM	0.00	0.00
EMERGENCY ROOM	254,643.03	16,809.20	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	37,051.35	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,201.70	5,853.60
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,026.35	816.10	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	963.70	2,104.10	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	706.75	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	608.00	4,739.80
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	37,461.65	4,123.05			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,555.80	5,928.35			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	55,745.15	19,834.34			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,702.00	353.10			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	604.75	604.75			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	325,413.87	18,386.45			
			TOTAL ANCILLARY	2,248,916.42	218,889.53
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,248,916.42	218,889.53

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

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	75,394.00	ADJUSTMENTS	0.00
COVERED CHARGES	63,638.12	CONTRACTUAL ALLOW	13,791.12
NON-COVERD CHARGES	11,755.88	TOTAL MEDICAID LIAB	49,847.00
		LESS: COB	49,826.00
		LESS: COPAYMENT	21.00
		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

STEPHENS COUNTY HOSPITAL
 163 HOSPITAL DR
 TOCCOA,GA 30577-6820

PROVIDER NUMBER
 000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,546.20	1,225.83	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	17,172.03	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,142.45	358.65	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,330.50	2,661.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	237.15	2,144.15	FEE SCHEDULE LAB	9,858.90	805.50
EKG/ECG	220.40	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	585.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,166.60	2,333.40	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	3,646.90	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,957.50	870.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,750.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	125.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,385.45	1,356.60			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,249.10	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	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,264.94	0.00			
			TOTAL ANCILLARY	63,638.12	11,755.88
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	63,638.12	11,755.88

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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	255,581.36	ADJUSTMENTS	214.76
COVERED CHARGES	239,392.02	CONTRACTUAL ALLOW	215,568.50
NON-COVERD CHARGES	16,189.34	TOTAL MEDICAID LIAB	23,823.52
		LESS: COB	1,139.08
		LESS: COPAYMENT	804.00
		REIMBURSEMENT	21,880.44
		TOTAL NUMBER OF CLAIMS	408

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,128.68	1,842.69	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,003.88	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,774.70	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	45,475.80	8,238.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	44,226.15	1,510.10
EKG/ECG	4,848.80	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,750.00	340.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	517.15	73.75	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	108,105.40	2,880.75	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	125.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,766.85	1,303.25			
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	669.61	0.00			
			TOTAL ANCILLARY	239,392.02	16,189.34
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	239,392.02	16,189.34

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,237.58	ADJUSTMENTS	0.00
COVERED CHARGES	3,076.78	CONTRACTUAL ALLOW	1,159.42
NON-COVERD CHARGES	160.80	TOTAL MEDICAID LIAB	1,917.36
		LESS: COB	1,917.36
		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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	275.57	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	179.31	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	715.55	0.00
EKG/ECG	220.40	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	1,465.95	160.80	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	3,076.78	160.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,076.78	160.80

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

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	372,890.12	ADJUSTMENTS	11,083.40
COVERED CHARGES	355,983.83	CONTRACTUAL ALLOW	250,624.46
NON-COVERD CHARGES	16,906.29	TOTAL MEDICAID LIAB	105,359.37
		LESS: COB	0.00
		LESS: COPAYMENT	61.24
		REIMBURSEMENT	105,298.13
		TOTAL NUMBER OF CLAIMS	19

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,654.88	1,839.80	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	156,189.07	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,457.65	1,504.90	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	53.05	0.00	FEE SCHEDULE LAB	3,965.40	0.00
EKG/ECG	440.80	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	320.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	86,464.23	10,733.34	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	320.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	32,139.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	804.50	374.70	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	16,708.35	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	43.00	43.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	608.00	1,893.95
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	196.60	196.60			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	42,938.80	0.00			
			TOTAL ANCILLARY	355,983.83	16,906.29
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	355,983.83	16,906.29

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: 08/24/2017
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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	10/01/15	THROUGH	09/30/16
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: 08/24/2017
 Run Time: 04:13:00
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WELLSTAR SYLVAN GROVE HOSPITAL, INC
 1050 MCDONOUGH RD
 JACKSON,GA 30233-1524

PROVIDER NUMBER 000001856A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,078.00	ADJUSTMENTS	6,793.81
COVERED CHARGES	14,883.00	CONTRACTUAL ALLOW	8,089.19
NON-COVERD CHARGES	195.00	TOTAL MEDICAID LIAB	6,793.81
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,793.81

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3		0	3,900.00		195.00
ROUTINE NURSERY	0		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	3,900.00		195.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	3,900.00		195.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

WELLSTAR SYLVAN GROVE HOSPITAL, INC
 1050 MCDONOUGH RD
 JACKSON,GA 30233-1524

PROVIDER NUMBER
 000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,672.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,572.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	556.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	199.50	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	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	981.75	0.00			
			TOTAL ANCILLARY	10,983.00	0.00
			TOTAL ACCOMODATIONS	3,900.00	195.00
			TOTAL CHARGES	14,883.00	195.00

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

WELLSTAR SYLVAN GROVE HOSPITAL, INC
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/16	THROUGH	03/31/16
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: 08/24/2017
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WELLSTAR SYLVAN GROVE HOSPITAL, INC
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	547,497.36	ADJUSTMENTS	10,971.38
COVERED CHARGES	500,624.96	CONTRACTUAL ALLOW	444,117.61
NON-COVERD CHARGES	46,872.40	TOTAL MEDICAID LIAB	56,507.35
		LESS: COB	0.00
		LESS: COPAYMENT	45.00
		REIMBURSEMENT	56,462.35
		ALL OTHER	50,829.97
		FEE SCHEDULE-LAB	4,998.70
		INJECTABLE DRUGS	633.68

TOTAL NUMBER OF CLAIMS 228

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: 08/24/2017
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WELLSTAR SYLVAN GROVE HOSPITAL, INC
 1050 MCDONOUGH RD
 JACKSON,GA 30233-1524

PROVIDER NUMBER
 000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,787.91	52.50	OTHER LAB	1,580.25	0.00
MED/SURG SUPPLY	7,822.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,260.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	57,230.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	42,525.00	22,596.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	370.65	1,496.25	FEE SCHEDULE LAB	75,304.57	4,284.00
EKG/ECG	9,828.00	409.50	MRI SERVICES	0.00	0.00
IV THERAPY	25,158.00	777.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	194.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,880.00	9,042.87	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	227,413.60	960.75	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	27,409.23	5,752.03
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	241.50	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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	120.75	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	500,624.96	46,872.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	500,624.96	46,872.40

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

WELLSTAR SYLVAN GROVE HOSPITAL, INC
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/16	THROUGH	03/31/16
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: 08/24/2017
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WELLSTAR SYLVAN GROVE HOSPITAL, INC
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	111,627.46	ADJUSTMENTS	144.00
COVERED CHARGES	105,106.95	CONTRACTUAL ALLOW	101,406.95
NON-COVERD CHARGES	6,520.51	TOTAL MEDICAID LIAB	3,700.00
		LESS: COB	0.00
		LESS: COPAYMENT	162.00
		REIMBURSEMENT	3,538.00

TOTAL NUMBER OF CLAIMS 74

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR SYLVAN GROVE HOSPITAL, INC
 1050 MCDONOUGH RD
 JACKSON,GA 30233-1524

PROVIDER NUMBER
 000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,815.95	21.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	955.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,688.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,137.50	4,903.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,457.75	1,029.00
EKG/ECG	819.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,428.50	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	567.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	67,221.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,016.50	567.01
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
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	105,106.95	6,520.51
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	105,106.95	6,520.51

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

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WELLSTAR SYLVAN GROVE HOSPITAL, INC
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/16	THROUGH	03/31/16
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

WELLSTAR SYLVAN GROVE HOSPITAL, INC
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/16	THROUGH	03/31/16
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: 08/24/2017
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR SYLVAN GROVE HOSPITAL, INC
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/16	THROUGH	03/31/16
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: 08/24/2017
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

WELLSTAR SYLVAN GROVE HOSPITAL, INC
 1050 MCDONOUGH RD
 JACKSON,GA 30233-1524

PROVIDER NUMBER 000001856A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	75,313.44	ADJUSTMENTS	0.00
COVERED CHARGES	74,468.44	CONTRACTUAL ALLOW	60,463.73
NON-COVERD CHARGES	845.00	TOTAL MEDICAID LIAB	14,004.71
		LESS: COB	882.78
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	13,121.93

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	13		0	16,900.00		845.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	13		0	16,900.00		845.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	13		0	16,900.00		845.00

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

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

Run Date: 08/24/2017
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

WELLSTAR SYLVAN GROVE HOSPITAL, INC
 1050 MCDONOUGH RD
 JACKSON,GA 30233-1524

PROVIDER NUMBER
 000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,461.29	0.00	OTHER LAB	1,974.00	0.00
MED/SURG SUPPLY	7,612.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,135.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,307.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	370.65	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	409.50	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	4,389.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,909.00	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	57,568.44	0.00
			TOTAL ACCOMODATIONS	16,900.00	845.00
			TOTAL CHARGES	74,468.44	845.00

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

WELLSTAR SYLVAN GROVE HOSPITAL, INC
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/16 THROUGH 06/30/16
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: 08/24/2017
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WELLSTAR SYLVAN GROVE HOSPITAL, INC
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/16 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	553,555.53	ADJUSTMENTS	4,860.42
COVERED CHARGES	533,661.51	CONTRACTUAL ALLOW	474,242.66
NON-COVERD CHARGES	19,894.02	TOTAL MEDICAID LIAB	59,418.85
		LESS: COB	0.00
		LESS: COPAYMENT	87.00
		REIMBURSEMENT	59,331.85
		ALL OTHER	54,112.62
		FEE SCHEDULE-LAB	4,548.21
		INJECTABLE DRUGS	671.02

TOTAL NUMBER OF CLAIMS 235

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: 08/24/2017
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WELLSTAR SYLVAN GROVE HOSPITAL, INC
 1050 MCDONOUGH RD
 JACKSON,GA 30233-1524

PROVIDER NUMBER
 000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,387.43	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,300.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	51,581.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	105,257.25	12,936.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,517.35	0.00	FEE SCHEDULE LAB	68,405.94	1,902.27
EKG/ECG	6,552.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	23,079.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,108.25	467.25	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	209,616.75	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	22,112.79	3,984.75
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	535.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	698.25	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	603.75	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	834.75	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	1,674.75	0.00			
			TOTAL ANCILLARY	533,661.51	19,894.02
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	533,661.51	19,894.02

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 SYLVAN GROVE HOSPITAL, INC
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/16 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,454.25	ADJUSTMENTS	0.00
COVERED CHARGES	1,401.75	CONTRACTUAL ALLOW	1,193.47
NON-COVERD CHARGES	52.50	TOTAL MEDICAID LIAB	208.28
		LESS: COB	208.28
		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

WELLSTAR SYLVAN GROVE HOSPITAL, INC
 1050 MCDONOUGH RD
 JACKSON,GA 30233-1524

PROVIDER NUMBER
 000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 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	57.75	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,344.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	52.50
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	1,401.75	52.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,401.75	52.50

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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WELLSTAR SYLVAN GROVE HOSPITAL, INC
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/16 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	165,958.14	ADJUSTMENTS	86.58
COVERED CHARGES	157,673.64	CONTRACTUAL ALLOW	153,823.64
NON-COVERD CHARGES	8,284.50	TOTAL MEDICAID LIAB	3,850.00
		LESS: COB	0.00
		LESS: COPAYMENT	193.69
		REIMBURSEMENT	3,656.31
		TOTAL NUMBER OF CLAIMS	77

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR SYLVAN GROVE HOSPITAL, INC
 1050 MCDONOUGH RD
 JACKSON,GA 30233-1524

PROVIDER NUMBER
 000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,576.10	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,260.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,621.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	32,508.00	6,468.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	16,558.50	981.75
EKG/ECG	2,457.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,770.00	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	451.50	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	72,098.25	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	6,373.29	834.75
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	157,673.64	8,284.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	157,673.64	8,284.50

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: 08/24/2017
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WELLSTAR SYLVAN GROVE HOSPITAL, INC
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/16	THROUGH	06/30/16
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

WELLSTAR SYLVAN GROVE HOSPITAL, INC
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/16	THROUGH	06/30/16
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: 08/24/2017
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR SYLVAN GROVE HOSPITAL, INC
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/16	THROUGH	06/30/16
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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 Run Time: 04:13:17
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,611,262.39	ADJUSTMENTS	1,782,030.75
COVERED CHARGES	20,552,608.42	CONTRACTUAL ALLOW	14,237,608.71
NON-COVERD CHARGES	58,653.97	TOTAL MEDICAID LIAB	6,314,999.71
		LESS: COB	72,255.54
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,242,744.17

TOTAL NUMBER OF ADMISSIONS 649

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,571		0	1,844,350.00		1,692.00
ROUTINE NURSERY	234		0	163,800.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,805		0	2,008,150.00		1,692.00
SPECIAL CARE SERVICES						
CCU	617		0	1,079,820.00		0.00
ICU	266		0	725,068.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	883		0	1,804,888.00		0.00
TOTAL ACCOMODATIONS	2,688		0	3,813,038.00		1,692.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,218,638.21	4,848.13	OTHER LAB	148,022.00	0.00
MED/SURG SUPPLY	1,315,229.95	454.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,404,085.26	18,689.00	EDUCATION & TRAINING	6,915.00	130.00
RADIOLOGY-DIAGNOSTIC	279,631.00	2,052.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	810,009.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	171,711.13	0.34	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	128,935.00	0.00	MRI SERVICES	204,599.00	0.00
IV THERAPY	333,307.00	2,570.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,738,823.00	3,770.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	333,756.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	980,344.00	1,795.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	356,997.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	103,820.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	655,921.00	245.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	79,861.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	48,082.00	0.00	INJECTABLE DRUGS	519,120.65	0.00
RADIOLOGY THERAPEUTIC	82,338.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	44,470.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	17,357.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	121,856.00	3,864.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	16,380.00	6,570.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,256,507.22	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	54,783.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	248,447.00	9,558.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	121,296.00	0.00			
AUDIOLOGY	12,155.00	0.00			
CARDIOLOGY	776,393.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,555.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	146,226.00	2,416.00			
			TOTAL ANCILLARY	16,739,570.42	56,961.97
			TOTAL ACCOMODATIONS	3,813,038.00	1,692.00
			TOTAL CHARGES	20,552,608.42	58,653.97

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: 08/24/2017
 Run Time: 04:13:23
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	170,553.66	ADJUSTMENTS	0.00
COVERED CHARGES	164,108.66	CONTRACTUAL ALLOW	45,079.00
NON-COVERD CHARGES	6,445.00	TOTAL MEDICAID LIAB	119,029.66
		LESS: COB	119,029.66
		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	13		0	15,275.00		0.00
ROUTINE NURSERY	3		0	2,100.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	16		0	17,375.00		0.00
SPECIAL CARE SERVICES						
CCU	3		0	5,250.00		0.00
ICU	2		0	5,450.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	5		0	10,700.00		0.00
TOTAL ACCOMODATIONS	21		0	28,075.00		0.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,241.67	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,271.49	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	16,521.00	0.00	EDUCATION & TRAINING	110.00	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	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,205.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,365.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,586.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	12,856.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,020.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,117.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,836.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	342.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	140.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,187.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	5,649.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	796.00			
AUDIOLOGY	125.00	0.00			
CARDIOLOGY	39,365.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	245.00	0.00			
			TOTAL ANCILLARY	136,033.66	6,445.00
			TOTAL ACCOMODATIONS	28,075.00	0.00
			TOTAL CHARGES	164,108.66	6,445.00

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,443,834.07	ADJUSTMENTS	490,107.80
COVERED CHARGES	18,550,190.08	CONTRACTUAL ALLOW	14,479,931.07
NON-COVERD CHARGES	893,643.99	TOTAL MEDICAID LIAB	4,070,259.01
		LESS: COB	2,072.74
		LESS: COPAYMENT	10,524.00
		REIMBURSEMENT	4,057,662.27
		ALL OTHER	3,703,264.33
		FEE SCHEDULE-LAB	198,881.16
		INJECTABLE DRUGS	155,516.78

TOTAL NUMBER OF CLAIMS 7,015

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: 08/24/2017
 Run Time: 04:13:25
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	706,030.03	902.14	OTHER LAB	156,575.00	1,197.00
MED/SURG SUPPLY	198,440.32	2,245.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	3,408.00	EDUCATION & TRAINING	0.00	2,010.00
RADIOLOGY-DIAGNOSTIC	716,774.00	12,184.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,091,505.00	204,280.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,170.00	6,295.00	FEE SCHEDULE LAB	2,281,662.00	44,086.47
EKG/ECG	239,795.00	1,446.00	MRI SERVICES	538,500.00	30,398.00
IV THERAPY	1,317,391.50	27,660.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,307,308.62	92,277.38	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	12,425.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	255,196.00	13,600.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	304,794.00	1,549.00	AMBULANCE	0.00	0.00
GI SERVICES	316,831.00	13,136.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,339,892.00	12,719.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	39,662.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	860,039.19	160,548.00
RADIOLOGY THERAPEUTIC	562,501.00	15,294.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,145.00	2,315.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,811.00	1,658.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	19,320.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	406,354.00	28,890.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	468,745.00	1,210.00	IMPL DEV CHARGE PATIENTS	98,619.12	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	730.00
OTHER IMAGING SERVICE	511,426.00	47,673.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	60,398.00	800.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	406,077.00	35,546.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	651,162.55	105,013.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	241,845.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	446,115.75	5,254.00			
			TOTAL ANCILLARY	18,550,190.08	893,643.99
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,550,190.08	893,643.99

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016197065008	06/30/16 - 06/30/16	07/18/16	0.00	365.00	0.00	0.00	0.00
905	2216214001544	06/24/16 - 06/24/16	08/08/16	0.00	365.00	0.00	0.00	0.00
TOTAL				0.00	730.00	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

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	184,459.61	ADJUSTMENTS	0.00
COVERED CHARGES	122,369.65	CONTRACTUAL ALLOW	42,078.42
NON-COVERD CHARGES	62,089.96	TOTAL MEDICAID LIAB	80,291.23
		LESS: COB	80,243.23
		LESS: COPAYMENT	48.00
		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

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,777.86	197.85	OTHER LAB	1,711.00	0.00
MED/SURG SUPPLY	975.96	3,533.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,317.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,715.00	22,416.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	16,605.00	1,006.00
EKG/ECG	1,928.00	241.00	MRI SERVICES	3,873.00	0.00
IV THERAPY	7,870.00	190.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	19,691.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	110.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,400.00	600.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,931.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,773.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	565.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,975.83	1,875.61
RADIOLOGY THERAPEUTIC	11,041.00	2,500.00	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	1,659.00	6,790.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	18,360.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,857.00	713.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,088.00	800.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,994.00	284.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,512.00	2,583.00			
			TOTAL ANCILLARY	122,369.65	62,089.96
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	122,369.65	62,089.96

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	836,381.02	ADJUSTMENTS	973.92
COVERED CHARGES	817,418.10	CONTRACTUAL ALLOW	784,133.80
NON-COVERD CHARGES	18,962.92	TOTAL MEDICAID LIAB	33,284.30
		LESS: COB	0.00
		LESS: COPAYMENT	1,124.44
		REIMBURSEMENT	32,159.86
		TOTAL NUMBER OF CLAIMS	595

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,964.66	0.00	OTHER LAB	4,768.00	0.00
MED/SURG SUPPLY	3,695.77	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	45.00
RADIOLOGY-DIAGNOSTIC	34,415.00	456.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	101,213.00	14,569.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	129,116.00	1,675.00
EKG/ECG	11,086.00	0.00	MRI SERVICES	4,028.00	0.00
IV THERAPY	61,785.00	255.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,967.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,130.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	840.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	398,490.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	342.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,774.67	278.92
RADIOLOGY THERAPEUTIC	10,604.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	237.00	140.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	14,056.00	1,544.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,362.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,544.00	0.00			
			TOTAL ANCILLARY	817,418.10	18,962.92
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	817,418.10	18,962.92

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

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	115.55	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	250.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,823.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,422.00	383.00
EKG/ECG	241.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,030.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,638.00	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,696.55	2,206.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,696.55	2,206.00

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

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,840,733.40	ADJUSTMENTS	133,715.23
COVERED CHARGES	3,656,806.60	CONTRACTUAL ALLOW	3,104,845.71
NON-COVERD CHARGES	183,926.80	TOTAL MEDICAID LIAB	551,960.89
		LESS: COB	0.00
		LESS: COPAYMENT	1,020.00
		REIMBURSEMENT	550,940.89

TOTAL NUMBER OF CLAIMS 95

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	121,476.07	0.00	OTHER LAB	1,904.00	0.00
MED/SURG SUPPLY	93,960.43	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	65.00
RADIOLOGY-DIAGNOSTIC	22,619.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,439.00	11,093.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	425.00	0.00	FEE SCHEDULE LAB	64,069.00	1,280.00
EKG/ECG	8,917.00	723.00	MRI SERVICES	0.00	3,873.00
IV THERAPY	132,976.00	2,560.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	443,230.00	22,968.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	14,831.00	1,200.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	44,060.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,486.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,306.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,539.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,429,128.06	92,314.80
RADIOLOGY THERAPEUTIC	701,544.00	1,800.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	295.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,971.00	560.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	221,060.04	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,484.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,496.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	4,785.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	246,595.00	40,410.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	47,291.00	0.00			
			TOTAL ANCILLARY	3,656,806.60	183,926.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,656,806.60	183,926.80

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: 08/24/2017
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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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
 Run Time: 04:14:49
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,130,958.97	ADJUSTMENTS	128,776.31
COVERED CHARGES	3,991,490.57	CONTRACTUAL ALLOW	3,675,330.26
NON-COVERD CHARGES	139,468.40	TOTAL MEDICAID LIAB	316,160.31
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	316,160.31

TOTAL NUMBER OF ADMISSIONS 33

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	64		0	47,936.00		139,468.40
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	64		0	47,936.00		139,468.40
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	64		0	47,936.00		139,468.40

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

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

Run Date: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	86,403.44	0.00	OTHER LAB	8,287.50	0.00
MED/SURG SUPPLY	23,768.77	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	38,019.58	0.00	EDUCATION & TRAINING	429.48	0.00
RADIOLOGY-DIAGNOSTIC	3,055.56	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,440.13	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,388.88	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,931.65	0.00	MRI SERVICES	6,056.96	0.00
IV THERAPY	5,070.98	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,528,059.33	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,174.34	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,000.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,400.16	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,577.79	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,997.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,181,795.84	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,048.44	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,648.24	0.00			
			TOTAL ANCILLARY	3,943,554.57	0.00
			TOTAL ACCOMODATIONS	47,936.00	139,468.40
			TOTAL CHARGES	3,991,490.57	139,468.40

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

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

Run Date: 08/24/2017
 Run Time: 04:14:50
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	667,347.02	ADJUSTMENTS	0.00
COVERED CHARGES	662,845.02	CONTRACTUAL ALLOW	333,522.69
NON-COVERD CHARGES	4,502.00	TOTAL MEDICAID LIAB	329,322.33
		LESS: COB	329,322.33
		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		0	1,498.00		4,502.00
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		0	1,498.00		4,502.00
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		0	1,498.00		4,502.00

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

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

Run Date: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,797.75	0.00	OTHER LAB	1,300.00	0.00
MED/SURG SUPPLY	1,541.01	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	104.40	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	508.86	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	350,833.60	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	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	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	301,200.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	661,347.02	0.00
			TOTAL ACCOMODATIONS	1,498.00	4,502.00
			TOTAL CHARGES	662,845.02	4,502.00

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: 08/24/2017
Run Time: 04:14:50
Page: 5

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,030,316.71	ADJUSTMENTS	79,498.72
COVERED CHARGES	4,768,733.26	CONTRACTUAL ALLOW	4,258,281.39
NON-COVERD CHARGES	261,583.45	TOTAL MEDICAID LIAB	510,451.87
		LESS: COB	4,453.28
		LESS: COPAYMENT	2,196.00
		REIMBURSEMENT	503,802.59
		ALL OTHER	461,238.13
		FEE SCHEDULE-LAB	42,547.31
		INJECTABLE DRUGS	17.15
		TOTAL NUMBER OF CLAIMS	1,661

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: 08/24/2017
 Run Time: 04:14:50
 Page: 6

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	95,157.45	61.57	OTHER LAB	64,718.10	1,000.00
MED/SURG SUPPLY	11,277.90	450.32	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	238.60
RADIOLOGY-DIAGNOSTIC	110,616.64	620.46	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	187,644.66	31,212.72	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,004.46	4,593.65	FEE SCHEDULE LAB	393,878.68	25,082.38
EKG/ECG	25,144.70	172.45	MRI SERVICES	211,621.48	0.00
IV THERAPY	39,521.91	3,102.36	PROFESSIONAL FEES	0.00	2,804.00
OPERATING ROOM	3,276,667.54	179,740.60	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,156.03	708.02	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,500.00	5,000.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	146,969.38	2,541.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,444.94	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	149.63	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,107.13	2,339.34	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	145,491.28	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	29,871.36	1,523.28			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	728.00	392.70			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,048.44	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,013.55	0.00			
			TOTAL ANCILLARY	4,768,733.26	261,583.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,768,733.26	261,583.45

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

Run Date: 08/24/2017
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Page: 7

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	132,963.57	ADJUSTMENTS	0.00
COVERED CHARGES	132,025.65	CONTRACTUAL ALLOW	75,535.77
NON-COVERD CHARGES	937.92	TOTAL MEDICAID LIAB	56,489.88
		LESS: COB	56,471.88
		LESS: COPAYMENT	18.00
		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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,466.44	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	235.48	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	303.72	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,555.04	341.92
EKG/ECG	172.45	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	729.04	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	112,621.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	133.16	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	1,837.84	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	363.48	596.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,608.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	132,025.65	937.92
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	132,025.65	937.92

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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	133,347.85	ADJUSTMENTS	141.00
COVERED CHARGES	122,005.48	CONTRACTUAL ALLOW	113,805.48
NON-COVERD CHARGES	11,342.37	TOTAL MEDICAID LIAB	8,200.00
		LESS: COB	46.10
		LESS: COPAYMENT	366.00
		REIMBURSEMENT	7,787.90
		TOTAL NUMBER OF CLAIMS	164

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,331.20	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	99.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,212.50	132.18	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,695.77	5,990.95	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	30,632.32	3,210.08
EKG/ECG	1,896.95	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,575.95	868.32	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	650.89	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	41,830.21	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13.26	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	1,990.80	1,140.84			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	75.88	0.00			
			TOTAL ANCILLARY	122,005.48	11,342.37
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	122,005.48	11,342.37

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

Run Date: 08/24/2017
Run Time: 04:15:00
Page: 11

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	01/01/16	THROUGH	12/31/16
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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,603,909.61	ADJUSTMENTS	33,965.90
COVERED CHARGES	2,374,706.68	CONTRACTUAL ALLOW	2,258,169.88
NON-COVERD CHARGES	229,202.93	TOTAL MEDICAID LIAB	116,536.80
		LESS: COB	0.00
		LESS: COPAYMENT	78.00
		REIMBURSEMENT	116,458.80

TOTAL NUMBER OF CLAIMS 24

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36,196.01	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	39,011.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	95.44
RADIOLOGY-DIAGNOSTIC	132.18	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	1,687.14	FEE SCHEDULE LAB	2,707.08	120.00
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	1,594,284.56	224,127.90	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	426.10	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,000.00	3,000.00	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	13,405.25	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	687,543.80	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,374,706.68	229,202.93
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,374,706.68	229,202.93

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

Run Date: 08/24/2017
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Page: 14

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	01/01/16	THROUGH	12/31/16
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: 08/24/2017
 Run Time: 04:15:42
 Page: 1

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,083,236.21	ADJUSTMENTS	564,477.67
COVERED CHARGES	28,112,220.50	CONTRACTUAL ALLOW	20,947,659.25
NON-COVERD CHARGES	971,015.71	TOTAL MEDICAID LIAB	7,164,561.25
		LESS: COB	54,063.17
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,110,498.08

TOTAL NUMBER OF ADMISSIONS 857

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,734		0	2,124,800.01		431,606.00
ROUTINE NURSERY	251		0	185,705.00		53,395.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,985		0	2,310,505.01		485,001.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	908		0	1,833,570.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	908		0	1,833,570.00		0.00
TOTAL ACCOMODATIONS	3,893		0	4,144,075.01		485,001.00

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,581,705.33	181.88	OTHER LAB	120,967.81	0.00
MED/SURG SUPPLY	1,517,766.37	13,312.78	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,152,143.90	0.00	EDUCATION & TRAINING	800.28	0.00
RADIOLOGY-DIAGNOSTIC	569,894.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,247,186.31	33,617.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	329,167.82	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	217,411.36	0.00	MRI SERVICES	271,354.03	0.00
IV THERAPY	95,022.15	0.00	PROFESSIONAL FEES	0.00	15,197.28
OPERATING ROOM	1,361,652.44	510.48	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	301,330.04	0.00	REHAB THERAPY	1,458.00	0.00
RESPIRATORY SERVICES	458,300.91	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	264,651.48	0.00	AMBULANCE	0.00	0.00
GI SERVICES	155,830.07	1,678.71	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,942,996.06	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	135,302.15	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	103,384.33	0.00	INJECTABLE DRUGS	3,167,529.93	0.00
RADIOLOGY THERAPEUTIC	23,678.35	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	82,075.39	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	18,248.67	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	56,902.50	4,215.00	PATIENT CONVENIENCE	0.00	111,495.84
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	12,751.43	651.34	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,101,917.46	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	155,985.52	6,810.68			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	428,462.46	254,453.90			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	120,639.29	43,889.57			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,379,777.05	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	37,436.82	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	554,415.78	0.00			
			TOTAL ANCILLARY	23,968,145.49	486,014.71
			TOTAL ACCOMODATIONS	4,144,075.01	485,001.00
			TOTAL CHARGES	28,112,220.50	971,015.71

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

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

Run Date: 08/24/2017
 Run Time: 04:15:53
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	521,235.84	ADJUSTMENTS	0.00
COVERED CHARGES	477,723.30	CONTRACTUAL ALLOW	78,489.91
NON-COVERD CHARGES	43,512.54	TOTAL MEDICAID LIAB	399,233.39
		LESS: COB	399,233.39
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 19

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	37		0	29,140.00		8,825.00
ROUTINE NURSERY	14		0	10,330.00		9,845.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	51		0	39,470.00		18,670.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	3		0	6,705.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	3		0	6,705.00		0.00
TOTAL ACCOMODATIONS	54		0	46,175.00		18,670.00

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55,413.01	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	20,080.92	305.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	36,276.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,519.77	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,849.76	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,223.96	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	953.72	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,488.51	0.00	PROFESSIONAL FEES	0.00	20,686.23
OPERATING ROOM	60,647.22	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	22,590.23	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,852.40	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,360.17	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,477.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,505.06	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,033.32	0.00	INJECTABLE DRUGS	39,592.12	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,562.18	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	578.13	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	109,060.23	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	469.08	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,026.68	3,850.56			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,608.66	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	758.61	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,621.31	0.00			
			TOTAL ANCILLARY	431,548.30	24,842.54
			TOTAL ACCOMODATIONS	46,175.00	18,670.00
			TOTAL CHARGES	477,723.30	43,512.54

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: 08/24/2017
Run Time: 04:15:56
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,499,756.74	ADJUSTMENTS	900,406.29
COVERED CHARGES	25,924,419.32	CONTRACTUAL ALLOW	21,836,190.46
NON-COVERD CHARGES	3,575,337.42	TOTAL MEDICAID LIAB	4,088,228.86
		LESS: COB	2,129.20
		LESS: COPAYMENT	12,290.39
		REIMBURSEMENT	4,073,809.27
		ALL OTHER	3,254,180.59
		FEE SCHEDULE-LAB	490,910.07
		INJECTABLE DRUGS	328,718.61
		TOTAL NUMBER OF CLAIMS	10,569

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,650,978.66	122,061.34	OTHER LAB	655,440.99	212.71
MED/SURG SUPPLY	670,635.43	32,889.19	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	89.50	EDUCATION & TRAINING	412.28	436.50
RADIOLOGY-DIAGNOSTIC	1,136,715.17	30,825.05	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,045,013.24	388,798.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,713.12	29,311.76	FEE SCHEDULE LAB	5,381,475.99	399,777.20
EKG/ECG	198,800.39	18,551.25	MRI SERVICES	650,326.54	89,844.93
IV THERAPY	636,246.45	47,991.48	PROFESSIONAL FEES	0.00	38,296.87
OPERATING ROOM	1,792,605.14	371,300.83	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	826.77	0.00	REHAB THERAPY	0.00	1,458.00
RESPIRATORY SERVICES	78,984.28	73,575.20	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	412,412.96	4,184.03	AMBULANCE	0.00	0.00
GI SERVICES	540,164.86	69,353.76	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,606,592.88	77,106.92	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	324,121.14	3,122.41	DRUG-SPECIFIC/HOME IV	0.00	1,491.75
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,359,484.76	772,532.54
RADIOLOGY THERAPEUTIC	677,718.65	288,645.52	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,258.18	11,379.38	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,183.47	12,355.72	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	18,967.50	PATIENT CONVENIENCE	0.00	3,658.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	122,559.77	9,047.24	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	145,735.51	24,177.27
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	10,121.65
OTHER IMAGING SERVICE	760,987.59	115,669.58			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	244,381.47	104,667.79			
ONCOLOGY	6,737.53	0.00			
NUCLEAR MEDICINE	428,241.75	281,645.81			
AUDIOLOGY	3,007.86	1,186.58			
CARDIOLOGY	602,173.63	57,496.48			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	36,982.05	2,703.48			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	731,500.81	60,403.70			
			TOTAL ANCILLARY	25,924,419.32	3,575,337.42
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,924,419.32	3,575,337.42

SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

TIFT REGIONAL MEDICAL CTR
 901 18TH ST E
 TIFTON,GA 31794-3648

PROVIDER NUMBER
 000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015329001425	10/05/15 - 10/05/15	11/30/15	0.00	255.00	0.00	0.00	0.00
948	2015329001444	10/07/15 - 10/07/15	11/30/15	0.00	255.00	0.00	0.00	0.00
948	2015329001444	10/14/15 - 10/14/15	11/30/15	0.00	255.00	0.00	0.00	0.00
948	2015329001444	10/19/15 - 10/19/15	11/30/15	0.00	255.00	0.00	0.00	0.00
948	2015329001444	10/21/15 - 10/21/15	11/30/15	0.00	255.00	0.00	0.00	0.00
948	2015329001444	10/30/15 - 10/30/15	11/30/15	0.00	255.00	0.00	0.00	0.00
780	2015330013807	10/21/15 - 10/21/15	11/30/15	0.00	34.25	0.00	0.00	0.00
948	2015342022781	11/04/15 - 11/04/15	12/14/15	0.00	255.00	0.00	0.00	0.00
948	2015342022781	11/09/15 - 11/09/15	12/14/15	0.00	255.00	0.00	0.00	0.00
948	2015342022781	11/11/15 - 11/11/15	12/14/15	0.00	255.00	0.00	0.00	0.00
948	2015342022781	11/18/15 - 11/18/15	12/14/15	0.00	255.00	0.00	0.00	0.00
948	2015342022781	11/20/15 - 11/20/15	12/14/15	0.00	127.50	0.00	0.00	0.00
948	2016056001971	12/15/15 - 12/15/15	02/29/16	0.00	255.00	0.00	0.00	0.00
948	2016056001971	12/22/15 - 12/22/15	02/29/16	0.00	255.00	0.00	0.00	0.00
948	2016056001971	12/24/15 - 12/24/15	02/29/16	0.00	255.00	0.00	0.00	0.00
948	2016056001971	12/29/15 - 12/29/15	02/29/16	0.00	257.84	0.00	0.00	0.00
948	2016056001988	12/01/15 - 12/01/15	02/29/16	0.00	255.00	0.00	0.00	0.00
948	2016056001988	12/02/15 - 12/02/15	02/29/16	0.00	255.00	0.00	0.00	0.00
948	2016056001988	12/09/15 - 12/09/15	02/29/16	0.00	255.00	0.00	0.00	0.00
948	2016068013923	02/01/16 - 02/01/16	03/14/16	0.00	265.88	0.00	0.00	0.00
948	2016068013923	02/03/16 - 02/03/16	03/14/16	0.00	265.88	0.00	0.00	0.00
948	2016068013923	02/08/16 - 02/08/16	03/14/16	0.00	132.94	0.00	0.00	0.00
948	2016068013923	02/15/16 - 02/15/16	03/14/16	0.00	265.88	0.00	0.00	0.00
948	2016068013923	02/17/16 - 02/17/16	03/14/16	0.00	265.88	0.00	0.00	0.00
948	2016068013923	02/22/16 - 02/22/16	03/14/16	0.00	265.88	0.00	0.00	0.00
948	2016068013923	02/24/16 - 02/24/16	03/14/16	0.00	265.88	0.00	0.00	0.00
948	2016133028553	04/18/16 - 04/18/16	05/16/16	0.00	265.88	0.00	0.00	0.00
948	2016133028553	04/20/16 - 04/20/16	05/16/16	0.00	265.88	0.00	0.00	0.00
948	2016133028644	04/06/16 - 04/06/16	05/16/16	0.00	265.88	0.00	0.00	0.00
948	2016133028644	04/11/16 - 04/11/16	05/16/16	0.00	265.88	0.00	0.00	0.00
948	2016133028644	04/13/16 - 04/13/16	05/16/16	0.00	531.76	0.00	0.00	0.00
780	2016211012150	07/13/16 - 07/13/16	08/01/16	0.00	34.25	0.00	0.00	0.00
9637	5916225000518	05/17/16 - 05/19/16	08/15/16	0.00	127.59	0.00	0.00	0.00
614	5916236000438	07/12/16 - 07/12/16	08/29/16	0.00	1,413.63	0.00	0.00	0.00
614	5916236000438	07/12/16 - 07/12/16	08/29/16	0.00	122.83	0.00	0.00	0.00
948	2216236004770	03/07/16 - 03/07/16	08/29/16	0.00	265.88	0.00	0.00	0.00
948	2216236004770	03/09/16 - 03/09/16	08/29/16	0.00	265.88	0.00	0.00	0.00
780	2016252109893	08/26/16 - 08/26/16	09/12/16	0.00	34.25	0.00	0.00	0.00
780	2016279071692	09/28/16 - 09/28/16	10/10/16	0.00	34.25	0.00	0.00	0.00
TOTAL				0.00	10,121.65	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: 08/24/2017
Run Time: 04:16:49
Page: 8

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	844,830.93	ADJUSTMENTS	0.00
COVERED CHARGES	634,154.98	CONTRACTUAL ALLOW	196,101.00
NON-COVERD CHARGES	210,675.95	TOTAL MEDICAID LIAB	438,053.98
		LESS: COB	437,840.95
		LESS: COPAYMENT	213.03
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 233

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	67,993.40	2,873.51	OTHER LAB	23,411.67	0.00
MED/SURG SUPPLY	19,785.52	1,169.81	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,661.97	5,392.23	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,393.23	39,447.12	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	7,987.38	FEE SCHEDULE LAB	128,183.44	12,563.04
EKG/ECG	5,415.50	705.52	MRI SERVICES	14,850.07	6,831.83
IV THERAPY	23,054.83	1,396.04	PROFESSIONAL FEES	0.00	54,551.09
OPERATING ROOM	56,745.10	7,336.24	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,934.70	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,943.89	0.00	AMBULANCE	0.00	0.00
GI SERVICES	14,323.22	2,400.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	73,984.77	1,472.14	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,008.89	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	49,385.68	16,025.33
RADIOLOGY THERAPEUTIC	10,606.78	982.77	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,405.00	PATIENT CONVENIENCE	0.00	1,024.24
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,941.15	567.60	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,915.44	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	31,540.69	7,073.98			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,059.35	8,710.71			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,473.26	10,051.97			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,086.67	17,182.36			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	30,455.76	3,526.04			
			TOTAL ANCILLARY	634,154.98	210,675.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	634,154.98	210,675.95

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: 08/24/2017
Run Time: 04:16:53
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	568,022.22	ADJUSTMENTS	1,832.74
COVERED CHARGES	515,239.02	CONTRACTUAL ALLOW	479,002.62
NON-COVERD CHARGES	52,783.20	TOTAL MEDICAID LIAB	36,236.40
		LESS: COB	0.00
		LESS: COPAYMENT	1,303.56
		REIMBURSEMENT	34,932.84
		TOTAL NUMBER OF CLAIMS	648

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,626.42	3,024.96	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,135.46	2,799.43	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	39,219.04	376.38	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	40,841.06	6,821.20	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	83,890.16	2,831.63
EKG/ECG	4,481.32	228.66	MRI SERVICES	0.00	5,079.93
IV THERAPY	17,474.37	886.25	PROFESSIONAL FEES	0.00	7,142.70
OPERATING ROOM	4,278.78	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	835.36	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	554.88	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	277,460.15	1,061.89	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,120.86	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,942.71	16,782.28
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	2,107.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	171.94	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,303.62	3,468.45			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	169.32	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,905.51	0.00			
			TOTAL ANCILLARY	515,239.02	52,783.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	515,239.02	52,783.20

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

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	62,718.28	ADJUSTMENTS	0.00
COVERED CHARGES	44,960.08	CONTRACTUAL ALLOW	17,099.38
NON-COVERD CHARGES	17,758.20	TOTAL MEDICAID LIAB	27,860.70
		LESS: COB	27,836.70
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	18

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,197.10	763.20	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	749.05	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,060.18	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,219.65	8,410.74	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,802.12	385.27
EKG/ECG	238.43	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,033.14	0.00	PROFESSIONAL FEES	0.00	6,296.39
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,625.29	1,705.81	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	285.40	196.79
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,665.06	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	84.66	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	44,960.08	17,758.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	44,960.08	17,758.20

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,649,221.18	ADJUSTMENTS	194,199.48
COVERED CHARGES	5,401,799.00	CONTRACTUAL ALLOW	4,758,671.50
NON-COVERD CHARGES	247,422.18	TOTAL MEDICAID LIAB	643,127.50
		LESS: COB	57,524.24
		LESS: COPAYMENT	714.00
		REIMBURSEMENT	584,889.26

TOTAL NUMBER OF CLAIMS 111

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	100,716.39	6,194.15	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	78,142.09	37,039.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	340.50	0.00
RADIOLOGY-DIAGNOSTIC	12,665.33	2,865.12	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,589.54	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,039.86	FEE SCHEDULE LAB	72,078.11	5,113.34
EKG/ECG	1,463.23	934.18	MRI SERVICES	8,018.24	0.00
IV THERAPY	38,857.37	1,939.47	PROFESSIONAL FEES	0.00	2,049.82
OPERATING ROOM	314,914.95	6,364.13	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	43,711.82	603.52	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,938.34	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,299.96	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,901.30	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,038,232.00	120,297.03
RADIOLOGY THERAPEUTIC	187,679.86	16,638.03	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	209.70	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	12,567.29	1,758.83	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	281,652.14	23,493.17
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	14,874.04	501.42			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	27,254.20	13,476.96			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,498.41	1,345.99			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	128,525.44	2,608.66			
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	18,878.45	2,948.90			
			TOTAL ANCILLARY	5,401,799.00	247,422.18
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,401,799.00	247,422.18

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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	120,270.09	ADJUSTMENTS	0.00
COVERED CHARGES	118,853.96	CONTRACTUAL ALLOW	22,477.23
NON-COVERD CHARGES	1,416.13	TOTAL MEDICAID LIAB	96,376.73
		LESS: COB	96,361.73
		LESS: COPAYMENT	15.00
		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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	783.43	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	245.06	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,305.46	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	912.15	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	112,855.10	1,416.13
RADIOLOGY THERAPEUTIC	2,618.37	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	134.39	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	118,853.96	1,416.13
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	118,853.96	1,416.13

** 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: 08/24/2017
 Run Time: 02:16:55
 Page: 1

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

CHATUGE REGIONAL HOSPITAL
 PO BOX 509
 HIAWASSEE,GA 30546-0509

PROVIDER NUMBER 000001933A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	98,522.35	ADJUSTMENTS	11,952.17
COVERED CHARGES	95,091.35	CONTRACTUAL ALLOW	37,292.20
NON-COVERD CHARGES	3,431.00	TOTAL MEDICAID LIAB	57,799.15
		LESS: COB	4,659.88
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	53,139.27

TOTAL NUMBER OF ADMISSIONS 10

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	32		0	24,000.00		2,400.00
ROUTINE NURSERY	0		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	24,000.00		2,400.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	4		0	4,800.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	4		0	4,800.00		0.00
TOTAL ACCOMODATIONS	36		0	28,800.00		2,400.00

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 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,923.00	0.00	OTHER LAB	2,250.00	0.00
MED/SURG SUPPLY	1,452.00	71.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	15,383.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,215.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,850.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,485.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	60.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,195.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,100.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,350.52	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,865.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,000.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,554.00	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	3,668.83	0.00			
			TOTAL ANCILLARY	66,291.35	1,031.00
			TOTAL ACCOMODATIONS	28,800.00	2,400.00
			TOTAL CHARGES	95,091.35	3,431.00

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

CHATUGE REGIONAL HOSPITAL
PO BOX 509
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/15 THROUGH 04/30/16
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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CHATUGE REGIONAL HOSPITAL
PO BOX 509
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	438,074.90	ADJUSTMENTS	3,161.62
COVERED CHARGES	405,421.85	CONTRACTUAL ALLOW	264,014.58
NON-COVERD CHARGES	32,653.05	TOTAL MEDICAID LIAB	141,407.27
		LESS: COB	80.80
		LESS: COPAYMENT	501.00
		REIMBURSEMENT	140,825.47
		ALL OTHER	122,301.20
		FEE SCHEDULE-LAB	17,902.26
		INJECTABLE DRUGS	622.01

TOTAL NUMBER OF CLAIMS 449

CHATUGE REGIONAL HOSPITAL
 PO BOX 509
 HIWASSEE,GA 30546-0509

PROVIDER NUMBER
 000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,602.00	8,263.00	OTHER LAB	5,790.00	0.00
MED/SURG SUPPLY	847.00	1,575.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	28,185.00	445.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	49,600.00	2,600.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	282.00	FEE SCHEDULE LAB	121,726.70	3,624.00
EKG/ECG	7,672.00	330.00	MRI SERVICES	9,484.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	120.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,045.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,100.00	2,200.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	139,321.86	372.60	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	9,012.00	3,346.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,015.00	3,000.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,490.00	900.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,300.00	175.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,000.00	1,850.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,231.29	3,570.45			
			TOTAL ANCILLARY	405,421.85	32,653.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	405,421.85	32,653.05

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

CHATUGE REGIONAL HOSPITAL
PO BOX 509
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,754.28	ADJUSTMENTS	0.00
COVERED CHARGES	5,350.08	CONTRACTUAL ALLOW	1,990.05
NON-COVERD CHARGES	404.20	TOTAL MEDICAID LIAB	3,360.03
		LESS: COB	3,360.03
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5

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

CHATUGE REGIONAL HOSPITAL
 PO BOX 509
 HIWASSEE,GA 30546-0509

PROVIDER NUMBER
 000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34.00	175.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	2.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	225.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,350.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	722.00	24.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,979.08	55.20	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	240.00	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	800.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	5,350.08	404.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,350.08	404.20

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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CHATUGE REGIONAL HOSPITAL
PO BOX 509
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,138.81	ADJUSTMENTS	0.00
COVERED CHARGES	21,654.81	CONTRACTUAL ALLOW	19,854.81
NON-COVERD CHARGES	484.00	TOTAL MEDICAID LIAB	1,800.00
		LESS: COB	0.00
		LESS: COPAYMENT	72.00
		REIMBURSEMENT	1,728.00
		TOTAL NUMBER OF CLAIMS	36

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

CHATUGE REGIONAL HOSPITAL
 PO BOX 509
 HIWASSEE,GA 30546-0509

PROVIDER NUMBER
 000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	529.00	275.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	11.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,350.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,632.00	133.00
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	95.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,686.81	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	197.00	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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	21,654.81	484.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	21,654.81	484.00

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

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ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHATUGE REGIONAL HOSPITAL
PO BOX 509
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	983.42	ADJUSTMENTS	0.00
COVERED CHARGES	983.42	CONTRACTUAL ALLOW	545.35
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	438.07
		LESS: COB	438.07
		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

CHATUGE REGIONAL HOSPITAL
PO BOX 509
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	51.00	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	337.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	595.42	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	983.42	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	983.42	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

CHATUGE REGIONAL HOSPITAL
PO BOX 509
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,100.00	ADJUSTMENTS	0.00
COVERED CHARGES	20,100.00	CONTRACTUAL ALLOW	15,382.51
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	4,717.49
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	4,714.49
		TOTAL NUMBER OF CLAIMS	1

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 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 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	20,000.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	100.00	0.00			
			TOTAL ANCILLARY	20,100.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	20,100.00	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: 08/24/2017
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Page: 14

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	05/01/15	THROUGH	04/30/16
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

UNION COUNTY HOSPITAL AUTHORITY
 35 HOSPITAL RD
 BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER 000001966A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	576,111.91	ADJUSTMENTS	53,958.97
COVERED CHARGES	568,211.91	CONTRACTUAL ALLOW	241,725.41
NON-COVERD CHARGES	7,900.00	TOTAL MEDICAID LIAB	326,486.50
		LESS: COB	3,373.24
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	323,113.26

TOTAL NUMBER OF ADMISSIONS 58

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	103		0	77,250.00		1,450.00
ROUTINE NURSERY	0		17	0.00		6,100.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	103		17	77,250.00		7,550.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	14		0	17,700.00		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	14		0	17,700.00		0.00
TOTAL ACCOMODATIONS	117		17	94,950.00		7,550.00

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 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	83,643.00	0.00	OTHER LAB	500.00	0.00
MED/SURG SUPPLY	15,332.00	140.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	60,425.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,999.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	34,200.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,692.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,305.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	23,500.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,650.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	111,942.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,300.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	51,299.28	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	750.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	393.75	0.00	INJECTABLE DRUGS	39,212.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	190.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,248.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,440.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,390.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,560.00	210.00			
AUDIOLOGY	1,600.00	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	11,190.88	0.00			
			TOTAL ANCILLARY	473,261.91	350.00
			TOTAL ACCOMODATIONS	94,950.00	7,550.00
			TOTAL CHARGES	568,211.91	7,900.00

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: 08/24/2017
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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 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,349.50	ADJUSTMENTS	0.00
COVERED CHARGES	10,249.50	CONTRACTUAL ALLOW	3,211.84
NON-COVERD CHARGES	100.00	TOTAL MEDICAID LIAB	7,037.66
		LESS: COB	7,037.66
		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	2,250.00		100.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3		0	2,250.00		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	3		0	2,250.00		100.00

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 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,908.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,037.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	225.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	1,500.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	577.50	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	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	305.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,327.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,999.50	0.00
			TOTAL ACCOMODATIONS	2,250.00	100.00
			TOTAL CHARGES	10,249.50	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: 08/24/2017
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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 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,066,498.36	ADJUSTMENTS	58,569.50
COVERED CHARGES	1,943,469.19	CONTRACTUAL ALLOW	1,402,654.13
NON-COVERD CHARGES	123,029.17	TOTAL MEDICAID LIAB	540,815.06
		LESS: COB	827.17
		LESS: COPAYMENT	1,401.00
		REIMBURSEMENT	538,586.89
		ALL OTHER	487,301.88
		FEE SCHEDULE-LAB	46,865.70
		INJECTABLE DRUGS	4,419.31
		TOTAL NUMBER OF CLAIMS	1,437

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 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	80,412.50	160.00	OTHER LAB	27,908.00	0.00
MED/SURG SUPPLY	1,890.00	2,929.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,256.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	138,489.00	1,201.00	OTHER THERAPEUTIC SVC	0.00	750.00
CT SCAN	326,580.00	8,400.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,555.00	298.00	FEE SCHEDULE LAB	286,716.70	20,533.00
EKG/ECG	32,019.00	1,025.00	MRI SERVICES	55,800.00	1,800.00
IV THERAPY	27,830.00	1,020.00	PROFESSIONAL FEES	0.00	450.00
OPERATING ROOM	167,018.00	10,625.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	385.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,663.00	10,835.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	21,600.00	550.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	555,001.08	2,665.42	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,600.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	52,803.00	29,253.75
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	280.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	188.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,800.00	441.60	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,836.00	10,803.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,820.00
OTHER IMAGING SERVICE	73,332.00	5,710.40			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,275.00	4,375.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	17,270.00	4,200.00			
AUDIOLOGY	160.00	0.00			
CARDIOLOGY	14,238.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	21,007.91	740.00			
			TOTAL ANCILLARY	1,943,469.19	123,029.17
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,943,469.19	123,029.17

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: 08/24/2017
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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 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016056000008	02/19/16 - 02/19/16	02/29/16	0.00	1,410.00	0.00	0.00	0.00
615	2016056000008	02/19/16 - 02/19/16	02/29/16	0.00	1,410.00	0.00	0.00	0.00
TOTAL				0.00	2,820.00	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: 08/24/2017
Run Time: 04:17:42
Page: 8

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 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	57,006.59	ADJUSTMENTS	0.00
COVERED CHARGES	52,458.59	CONTRACTUAL ALLOW	13,609.48
NON-COVERD CHARGES	4,548.00	TOTAL MEDICAID LIAB	38,849.11
		LESS: COB	38,825.11
		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

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 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,406.00	610.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	16.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	861.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,370.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,628.10	717.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,080.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	20,200.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,200.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,192.33	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,150.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,433.00	194.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	811.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,400.40	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	737.76	0.00			
			TOTAL ANCILLARY	52,458.59	4,548.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	52,458.59	4,548.00

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: 08/24/2017
Run Time: 04:17:42
Page: 10

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 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	113,132.68	ADJUSTMENTS	420.52
COVERED CHARGES	110,575.68	CONTRACTUAL ALLOW	104,646.04
NON-COVERD CHARGES	2,557.00	TOTAL MEDICAID LIAB	5,929.64
		LESS: COB	0.00
		LESS: COPAYMENT	221.19
		REIMBURSEMENT	5,708.45
		TOTAL NUMBER OF CLAIMS	106

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 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,931.00	0.00	OTHER LAB	2,160.00	0.00
MED/SURG SUPPLY	0.00	46.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	304.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,411.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,890.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,145.00	653.00
EKG/ECG	1,845.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,450.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	82.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	59,390.27	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,262.00	1,554.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,936.80	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,072.11	0.00			
			TOTAL ANCILLARY	110,575.68	2,557.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	110,575.68	2,557.00

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: 08/24/2017
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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 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,634.82	ADJUSTMENTS	0.00
COVERED CHARGES	1,378.42	CONTRACTUAL ALLOW	712.04
NON-COVERD CHARGES	256.40	TOTAL MEDICAID LIAB	666.38
		LESS: COB	666.38
		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

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 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 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	243.00	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	595.42	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	540.00	248.40			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,378.42	256.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,378.42	256.40

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

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	05/01/15	THROUGH	04/30/16
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: 08/24/2017
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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	05/01/15	THROUGH	04/30/16
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

UNIVERSITY HOSPITAL
 1350 WALTON WAY
 AUGUSTA, GA 30901-2612

PROVIDER NUMBER 000001977A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	49,024,285.49	ADJUSTMENTS	1,186,142.35
COVERED CHARGES	48,785,177.01	CONTRACTUAL ALLOW	34,525,573.60
NON-COVERD CHARGES	239,108.48	TOTAL MEDICAID LIAB	14,259,603.41
		LESS: COB	207,796.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	14,051,807.32

TOTAL NUMBER OF ADMISSIONS 1,332

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,411	16	1,972,000.00	15,660.00
ROUTINE NURSERY	690	0	682,033.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4,101	16	2,654,033.00	15,660.00
SPECIAL CARE SERVICES				
CCU	163	0	264,875.00	0.00
ICU	3,903	7	4,193,192.00	18,487.00
NICU	117	0	190,125.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	4,183	7	4,648,192.00	18,487.00
TOTAL ACCOMODATIONS	8,284	23	7,302,225.00	34,147.00

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,004,905.85	17,383.13	OTHER LAB	293,420.00	0.00
MED/SURG SUPPLY	8,206,364.56	26,530.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,340,042.67	3,669.35	EDUCATION & TRAINING	33,260.00	0.00
RADIOLOGY-DIAGNOSTIC	1,095,061.00	241.00	OTHER THERAPEUTIC SVC	47,642.00	12,336.00
CT SCAN	2,039,249.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	278,690.00	900.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	303,572.00	786.00	MRI SERVICES	639,086.00	0.00
IV THERAPY	288,685.00	560.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,922,693.00	798.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	109,042.00	0.00	REHAB THERAPY	2,160.00	0.00
RESPIRATORY SERVICES	2,778,877.00	11,536.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	209,532.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	259,639.00	0.00	CAST ROOM	404.00	0.00
EMERGENCY ROOM	1,022,339.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	177,300.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	248,995.65	0.00	INJECTABLE DRUGS	830.00	0.00
RADIOLOGY THERAPEUTIC	669.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	95,581.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	62,285.00	474.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	337,770.00	29,970.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	36,855.00	3,846.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	992,948.82	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	43,444.00
OTHER IMAGING SERVICE	183,432.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	669,733.46	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	209,678.00	51,438.00			
AUDIOLOGY	21,599.00	0.00			
CARDIOLOGY	2,017,552.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	42,328.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	510,731.00	1,050.00			
			TOTAL ANCILLARY	41,482,952.01	204,961.48
			TOTAL ACCOMODATIONS	7,302,225.00	34,147.00
			TOTAL CHARGES	48,785,177.01	239,108.48

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

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

Run Date: 08/24/2017
 Run Time: 04:17:50
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016056078885	01/29/16 - 01/31/16	02/29/16	0.00	2,613.00	0.00	0.00	0.00
615	2216067004153	01/17/16 - 01/19/16	03/14/16	0.00	2,613.00	0.00	0.00	0.00
615	2016120055855	01/08/16 - 01/20/16	05/02/16	0.00	2,613.00	0.00	0.00	0.00
615	2016265043578	09/12/16 - 09/15/16	09/26/16	0.00	2,613.00	0.00	0.00	0.00
615	2016266051985	09/16/16 - 09/18/16	09/26/16	0.00	2,613.00	0.00	0.00	0.00
-1	2316281000093	06/02/16 - 06/09/16	11/07/16	0.00	4,249.00	0.00	1,126.60	0.00
615	2016363024284	11/24/16 - 12/06/16	01/02/17	0.00	2,613.00	0.00	0.00	0.00
615	2017009010959	12/26/16 - 01/04/17	01/16/17	0.00	2,613.00	0.00	0.00	0.00
615	2217032000896	08/02/16 - 08/16/16	02/06/17	0.00	2,613.00	0.00	0.00	0.00
615	2317038000061	11/06/16 - 11/11/16	02/27/17	0.00	2,613.00	0.00	3,308.27	0.00
615	2017051013788	08/18/16 - 08/26/16	02/27/17	0.00	2,613.00	0.00	0.00	0.00
615	2017055063528	03/14/16 - 03/16/16	02/27/17	0.00	2,613.00	0.00	0.00	0.00
615	2017100010800	04/08/16 - 04/12/16	04/17/17	0.00	2,613.00	0.00	0.00	0.00
615	2017104061163	05/20/16 - 06/08/16	04/17/17	0.00	2,613.00	0.00	0.00	0.00
615	2317177000008	05/08/16 - 05/18/16	07/24/17	0.00	2,613.00	0.00	2,306.48	0.00
615	2017212007790	09/21/16 - 09/27/16	08/07/17	0.00	2,613.00	0.00	0.00	0.00
TOTAL				0.00	43,444.00	0.00	6,741.35	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: 08/24/2017
 Run Time: 04:18:07
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	633,799.42	ADJUSTMENTS	0.00
COVERED CHARGES	633,660.42	CONTRACTUAL ALLOW	370,752.63
NON-COVERD CHARGES	139.00	TOTAL MEDICAID LIAB	262,907.79
		LESS: COB	262,907.79
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 26

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	68		0	39,440.00		0.00
ROUTINE NURSERY	53		0	55,924.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	121		0	95,364.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	38		0	36,974.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	38		0	36,974.00		0.00
TOTAL ACCOMODATIONS	159		0	132,338.00		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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	126,640.15	0.00	OTHER LAB	6,388.00	0.00
MED/SURG SUPPLY	122,393.15	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	44,465.64	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,199.00	0.00	OTHER THERAPEUTIC SVC	0.00	139.00
CT SCAN	5,328.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,191.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,572.00	0.00	MRI SERVICES	5,335.00	0.00
IV THERAPY	516.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	55,371.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	15,760.00	0.00	REHAB THERAPY	15.00	0.00
RESPIRATORY SERVICES	27,466.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,958.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,160.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,089.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	7,460.48	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,497.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	525.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	945.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	352.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,636.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	1,302.00	0.00			
CARDIOLOGY	45,482.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,276.00	0.00			
			TOTAL ANCILLARY	501,322.42	139.00
			TOTAL ACCOMODATIONS	132,338.00	0.00
			TOTAL CHARGES	633,660.42	139.00

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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,940,259.94	ADJUSTMENTS	943,461.25
COVERED CHARGES	20,491,669.59	CONTRACTUAL ALLOW	16,359,779.95
NON-COVERD CHARGES	1,448,590.35	TOTAL MEDICAID LIAB	4,131,889.64
		LESS: COB	45,984.91
		LESS: COPAYMENT	13,783.73
		REIMBURSEMENT	4,072,121.00
		ALL OTHER	2,829,933.51
		FEE SCHEDULE-LAB	413,374.45
		INJECTABLE DRUGS	828,813.04
		TOTAL NUMBER OF CLAIMS	11,614

UNIVERSITY HOSPITAL
 1350 WALTON WAY
 AUGUSTA,GA 30901-2612

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 000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,011,793.05	10,698.61	OTHER LAB	341,717.00	290.00
MED/SURG SUPPLY	1,952,475.36	61,396.36	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	60.19	EDUCATION & TRAINING	704.00	3,149.00
RADIOLOGY-DIAGNOSTIC	880,049.00	4,020.00	OTHER THERAPEUTIC SVC	174.00	1,356.00
CT SCAN	2,418,983.00	341,427.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	16,901.00	8,816.00	FEE SCHEDULE LAB	2,628,874.16	42,375.49
EKG/ECG	347,370.00	5,408.00	MRI SERVICES	628,741.00	69,610.00
IV THERAPY	1,242,688.00	3,028.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	862,745.81	117,455.19	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	64,328.00	0.00	REHAB THERAPY	90.00	388.00
RESPIRATORY SERVICES	188,579.00	9,913.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	88,278.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	186,369.50	20,731.00	CAST ROOM	8,806.00	0.00
EMERGENCY ROOM	2,565,101.00	341.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	153,626.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,267,806.99	480,617.51
RADIOLOGY THERAPEUTIC	40,135.00	197.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	17,508.00	5,109.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,540.00	3,223.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,620.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	246,416.00	15,297.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	59,333.96	774.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	4,993.00
OTHER IMAGING SERVICE	616,809.00	37,987.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	80,040.76	1,176.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	413,177.00	58,473.00			
AUDIOLOGY	1,522.00	0.00			
CARDIOLOGY	706,992.00	107,577.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	14,300.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	436,696.00	31,084.00			
			TOTAL ANCILLARY	20,491,669.59	1,448,590.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	20,491,669.59	1,448,590.35

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016165015123	02/16/16 - 02/16/16	06/20/16	0.00	238.00	0.00	0.00	0.00
948	2016165015127	02/29/16 - 02/29/16	06/20/16	0.00	238.00	0.00	0.00	0.00
948	2016260076523	05/27/16 - 05/27/16	09/19/16	0.00	238.00	0.00	0.00	0.00
948	2016263013547	08/18/16 - 08/18/16	09/26/16	0.00	238.00	0.00	0.00	0.00
948	2016263013548	08/25/16 - 08/25/16	09/26/16	0.00	238.00	0.00	0.00	0.00
948	2016286025430	09/14/16 - 09/14/16	10/17/16	0.00	238.00	0.00	0.00	0.00
948	2016286025431	09/19/16 - 09/19/16	10/17/16	0.00	238.00	0.00	0.00	0.00
948	2016286025432	10/03/16 - 10/03/16	10/17/16	0.00	238.00	0.00	0.00	0.00
948	2016319014015	10/10/16 - 10/10/16	11/21/16	0.00	238.00	0.00	0.00	0.00
948	2016319014016	10/24/16 - 10/24/16	11/21/16	0.00	238.00	0.00	0.00	0.00
615	9817153000074	01/26/16 - 01/26/16	06/12/17	0.00	2,613.00	0.00	0.00	0.00
TOTAL				0.00	4,993.00	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

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	382,447.25	ADJUSTMENTS	0.00
COVERED CHARGES	280,200.00	CONTRACTUAL ALLOW	173,437.57
NON-COVERD CHARGES	102,247.25	TOTAL MEDICAID LIAB	106,762.43
		LESS: COB	106,559.95
		LESS: COPAYMENT	202.48
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 141

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,084.15	0.00	OTHER LAB	10,893.00	0.00
MED/SURG SUPPLY	43,008.07	3,945.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	20.00	0.00
RADIOLOGY-DIAGNOSTIC	8,174.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,274.00	21,180.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	28,694.65	1,606.00
EKG/ECG	2,882.00	0.00	MRI SERVICES	14,727.00	13,764.00
IV THERAPY	27,868.00	189.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	18,491.00	7,196.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,047.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	1,182.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,300.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	10,086.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,723.00	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	37,748.67	37,373.25
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	143.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	563.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	302.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	289.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	238.00
OTHER IMAGING SERVICE	4,342.00	2,246.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,447.46	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,258.00	401.00			
AUDIOLOGY	395.00	0.00			
CARDIOLOGY	175.00	1,709.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	572.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,252.00	137.00			
			TOTAL ANCILLARY	280,200.00	102,247.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	280,200.00	102,247.25

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

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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016165015125	02/22/16 - 02/22/16	06/20/16	0.00	238.00	0.00	0.00	0.00
TOTAL				0.00	238.00	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

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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	307,784.69	ADJUSTMENTS	267.70
COVERED CHARGES	298,053.69	CONTRACTUAL ALLOW	276,181.15
NON-COVERD CHARGES	9,731.00	TOTAL MEDICAID LIAB	21,872.54
		LESS: COB	0.00
		LESS: COPAYMENT	701.63
		REIMBURSEMENT	21,170.91
		TOTAL NUMBER OF CLAIMS	391

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,935.95	0.00	OTHER LAB	2,925.00	0.00
MED/SURG SUPPLY	10,405.44	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,393.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,660.00	9,064.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	56,602.70	0.00
EKG/ECG	9,694.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	16,177.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	148,700.00	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	8,348.60	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	177.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,035.00	667.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	298,053.69	9,731.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	298,053.69	9,731.00

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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UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,463.54	ADJUSTMENTS	0.00
COVERED CHARGES	7,383.54	CONTRACTUAL ALLOW	2,561.89
NON-COVERD CHARGES	80.00	TOTAL MEDICAID LIAB	4,821.65
		LESS: COB	4,815.65
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	282.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,234.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	241.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,375.04	80.00
EKG/ECG	0.00	0.00	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	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	2,569.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	333.50	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	7,383.54	80.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,383.54	80.00

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

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,663,580.79	ADJUSTMENTS	204,144.75
COVERED CHARGES	2,373,468.11	CONTRACTUAL ALLOW	1,892,260.77
NON-COVERD CHARGES	1,290,112.68	TOTAL MEDICAID LIAB	481,207.34
		LESS: COB	0.00
		LESS: COPAYMENT	339.00
		REIMBURSEMENT	480,868.34
		TOTAL NUMBER OF CLAIMS	89

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45,948.43	0.00	OTHER LAB	133.00	0.00
MED/SURG SUPPLY	563,905.54	443,900.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	72,684.00	5,879.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,776.00	717.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,313.60	628.00
EKG/ECG	4,192.00	262.00	MRI SERVICES	0.00	0.00
IV THERAPY	33,803.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	838,653.70	247,189.30	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	15.00
RESPIRATORY SERVICES	1,253.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,833.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,080.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,072.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	531,762.84	35,142.38
RADIOLOGY THERAPEUTIC	1,134.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	378.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,200.00	385,617.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	533.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	628.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	202,013.00	170,385.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	31,550.00	0.00			
			TOTAL ANCILLARY	2,373,468.11	1,290,112.68
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,373,468.11	1,290,112.68

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

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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	100,083.74	ADJUSTMENTS	0.00
COVERED CHARGES	43,767.13	CONTRACTUAL ALLOW	559.32
NON-COVERD CHARGES	56,316.61	TOTAL MEDICAID LIAB	43,207.81
		LESS: COB	43,204.81
		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

UNIVERSITY HOSPITAL
 1350 WALTON WAY
 AUGUSTA,GA 30901-2612

PROVIDER NUMBER
 000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	460.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,500.34	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	366.00	20.00
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	37,548.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	630.04	386.61
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	53,367.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	2,543.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	43,767.13	56,316.61
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	43,767.13	56,316.61

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

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

Run Date: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,452,175.42	ADJUSTMENTS	236,849.35
COVERED CHARGES	10,400,762.72	CONTRACTUAL ALLOW	7,057,114.15
NON-COVERD CHARGES	51,412.70	TOTAL MEDICAID LIAB	3,343,648.57
		LESS: COB	51,012.66
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,292,635.91

TOTAL NUMBER OF ADMISSIONS 363

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,046		0	1,088,265.00		28,158.00
ROUTINE NURSERY	70		0	55,090.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,116		0	1,143,355.00		28,158.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	373		0	643,932.00		0.00
NICU	39		0	43,836.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	412		0	687,768.00		0.00
TOTAL ACCOMODATIONS	1,528		0	1,831,123.00		28,158.00

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	318,949.83	2,125.00	OTHER LAB	31,415.00	0.00
MED/SURG SUPPLY	666,571.17	2,882.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,023,558.25	0.00	EDUCATION & TRAINING	53.00	0.00
RADIOLOGY-DIAGNOSTIC	214,745.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	618,646.00	3,955.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	233,858.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	97,524.00	0.00	MRI SERVICES	97,083.00	0.00
IV THERAPY	199,287.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,509,024.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	95,980.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	537,074.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	66,111.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	115,528.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	393,959.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	253,279.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	3,180.00
LABORATORY PATHOLOGIC	43,817.00	0.00	INJECTABLE DRUGS	1,043,411.27	236.20
RADIOLOGY THERAPEUTIC	1,485.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	345.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	81,800.00	0.00	PATIENT CONVENIENCE	0.00	72.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,007.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	559,247.20	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	47,666.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	140,054.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	30,278.00	9,460.00			
AUDIOLOGY	3,916.00	1,344.00			
CARDIOLOGY	95,563.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,162.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	41,243.00	0.00			
			TOTAL ANCILLARY	8,569,639.72	23,254.70
			TOTAL ACCOMODATIONS	1,831,123.00	28,158.00
			TOTAL CHARGES	10,400,762.72	51,412.70

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	100,238.24	ADJUSTMENTS	0.00
COVERED CHARGES	99,235.74	CONTRACTUAL ALLOW	43,154.54
NON-COVERD CHARGES	1,002.50	TOTAL MEDICAID LIAB	56,081.20
		LESS: COB	56,081.20
		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	16		0	16,374.00		714.00
ROUTINE NURSERY	0		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	16,374.00		714.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	16		0	16,374.00		714.00

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,906.31	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,380.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,911.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,410.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,232.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,625.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,110.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	16,465.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,238.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	435.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,578.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,694.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	288.50
LABORATORY PATHOLOGIC	2,378.00	0.00	INJECTABLE DRUGS	8,314.43	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	6,135.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	143.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,746.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,160.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	82,861.74	288.50
			TOTAL ACCOMODATIONS	16,374.00	714.00
			TOTAL CHARGES	99,235.74	1,002.50

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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,050,418.69	ADJUSTMENTS	427,020.45
COVERED CHARGES	11,669,526.46	CONTRACTUAL ALLOW	9,860,852.85
NON-COVERD CHARGES	380,892.23	TOTAL MEDICAID LIAB	1,808,673.61
		LESS: COB	2,138.89
		LESS: COPAYMENT	4,371.92
		REIMBURSEMENT	1,802,162.80
		ALL OTHER	1,619,317.33
		FEE SCHEDULE-LAB	145,266.13
		INJECTABLE DRUGS	37,579.34

TOTAL NUMBER OF CLAIMS 3,954

SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

UPSON REGIONAL MEDICAL CENTER
 801 W GORDON ST
 THOMASTON,GA 30286-3426

PROVIDER NUMBER
 000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	59,226.56	2,546.90	OTHER LAB	102,005.00	5,110.00
MED/SURG SUPPLY	336,719.91	7,064.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	4,869.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	620,573.00	9,869.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,179,481.00	43,824.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	153,015.00	38,224.03	FEE SCHEDULE LAB	1,588,828.90	39,732.00
EKG/ECG	195,297.00	5,805.00	MRI SERVICES	314,772.00	11,719.00
IV THERAPY	631,548.00	2,322.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,245,868.00	78,978.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	31,224.00	0.00	REHAB THERAPY	2,737.00	0.00
RESPIRATORY SERVICES	30,314.00	4,585.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	59,599.00	2,805.00	AMBULANCE	0.00	0.00
GI SERVICES	231,668.00	3,579.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,219,624.00	4,756.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	307,741.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	318,891.09	74,697.30
RADIOLOGY THERAPEUTIC	7,849.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	345.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,045.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,575.00	7,150.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	124,037.00	0.00
LITHOTRIPSY	39,256.00	0.00	NO CC/INVALID REV CODE	0.00	216.00
OTHER IMAGING SERVICE	202,164.00	23,539.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	30,468.00	1,568.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	89,171.00	303.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	64,052.00	4,731.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	114,114.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	366,708.00	510.00			
			TOTAL ANCILLARY	11,669,526.46	380,892.23
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,669,526.46	380,892.23

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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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
9637	5916207001175	06/06/16 - 06/06/16	08/01/16	0.00	178.00	0.00	0.00	0.00
8296	5916328000405	10/17/16 - 10/17/16	11/28/16	0.00	38.00	0.00	0.00	0.00
TOTAL				0.00	216.00	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

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	175,279.48	ADJUSTMENTS	0.00
COVERED CHARGES	110,519.48	CONTRACTUAL ALLOW	34,119.26
NON-COVERD CHARGES	64,760.00	TOTAL MEDICAID LIAB	76,400.22
		LESS: COB	76,355.37
		LESS: COPAYMENT	44.85
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 60

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	856.13	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,850.00	716.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,042.00	5,492.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	27,021.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	22,258.00	702.00
EKG/ECG	1,161.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	11,920.00	0.00	PROFESSIONAL FEES	0.00	678.00
OPERATING ROOM	2,321.00	11,755.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	831.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	38,253.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,694.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,378.35	1,083.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,045.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	286.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	455.00	831.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,867.00	0.00			
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	14,151.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,162.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,239.00	0.00			
			TOTAL ANCILLARY	110,519.48	64,760.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	110,519.48	64,760.00

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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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	628,001.36	ADJUSTMENTS	1,040.79
COVERED CHARGES	622,280.16	CONTRACTUAL ALLOW	597,946.26
NON-COVERD CHARGES	5,721.20	TOTAL MEDICAID LIAB	24,333.90
		LESS: COB	0.00
		LESS: COPAYMENT	921.78
		REIMBURSEMENT	23,412.12
		TOTAL NUMBER OF CLAIMS	435

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,863.95	0.00	OTHER LAB	2,358.00	0.00
MED/SURG SUPPLY	2,608.39	483.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	324.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	35,067.00	954.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	94,083.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	88,254.50	608.00
EKG/ECG	9,675.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	36,935.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	324,021.00	306.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	15,851.32	3,046.20
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,563.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	622,280.16	5,721.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	622,280.16	5,721.20

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

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,642.35	ADJUSTMENTS	0.00
COVERED CHARGES	16,678.35	CONTRACTUAL ALLOW	7,744.08
NON-COVERD CHARGES	3,964.00	TOTAL MEDICAID LIAB	8,934.27
		LESS: COB	8,931.27
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	10

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	111.00	53.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,954.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,590.00	0.00
EKG/ECG	387.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,318.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,202.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	913.60	36.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,120.00	921.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	16,678.35	3,964.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,678.35	3,964.00

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

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	385,447.21	ADJUSTMENTS	22,150.92
COVERED CHARGES	379,851.71	CONTRACTUAL ALLOW	324,399.41
NON-COVERD CHARGES	5,595.50	TOTAL MEDICAID LIAB	55,452.30
		LESS: COB	0.00
		LESS: COPAYMENT	138.00
		REIMBURSEMENT	55,314.30
		TOTAL NUMBER OF CLAIMS	10

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,226.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	41,496.50	1,375.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,726.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	936.00	FEE SCHEDULE LAB	3,591.00	0.00
EKG/ECG	1,935.00	387.00	MRI SERVICES	0.00	0.00
IV THERAPY	28,301.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	162,956.00	3.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,867.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	735.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	24,246.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,561.96	2,227.50
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	66,366.00	0.00
LITHOTRIPSY	19,628.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	667.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,216.00	0.00			
			TOTAL ANCILLARY	379,851.71	5,595.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	379,851.71	5,595.50

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: 08/24/2017
Run Time: 04:20:27
Page: 16

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	01/01/16	THROUGH	12/31/16
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: 08/24/2017
 Run Time: 03:32:58
 Page: 1

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,007,777.44	ADJUSTMENTS	188,115.40
COVERED CHARGES	2,943,852.94	CONTRACTUAL ALLOW	2,505,264.20
NON-COVERD CHARGES	63,924.50	TOTAL MEDICAID LIAB	438,588.74
		LESS: COB	1,192.08
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	437,396.66

TOTAL NUMBER OF ADMISSIONS 13

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	64		0	48,002.00		33,022.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	64		0	48,002.00		33,022.00
SPECIAL CARE SERVICES						
CCU	381		0	943,915.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	381		0	943,915.00		0.00
TOTAL ACCOMODATIONS	445		0	991,917.00		33,022.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	402,966.00	8,524.50	OTHER LAB	11,818.00	264.00
MED/SURG SUPPLY	96,550.92	1,897.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	255,070.00	3,021.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	52,741.00	0.00	OTHER THERAPEUTIC SVC	0.00	1,159.00
CT SCAN	72,044.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	57,922.02	5,089.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,023.00	0.00	MRI SERVICES	4,678.00	0.00
IV THERAPY	8,894.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	23,788.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	849,520.00	366.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,136.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,084.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,073.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	570.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	23,923.00	3,511.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	45,400.00	2,402.00	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	222.00	222.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,486.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,688.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,440.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,759.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,693.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,447.00	4,447.00			
			TOTAL ANCILLARY	1,951,935.94	30,902.50
			TOTAL ACCOMODATIONS	991,917.00	33,022.00
			TOTAL CHARGES	2,943,852.94	63,924.50

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

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 07/01/15 THROUGH 06/30/16
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: 08/24/2017
Run Time: 03:32:58
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,761,393.53	ADJUSTMENTS	71,728.94
COVERED CHARGES	2,471,684.94	CONTRACTUAL ALLOW	1,953,729.70
NON-COVERD CHARGES	289,708.59	TOTAL MEDICAID LIAB	517,955.24
		LESS: COB	8,495.55
		LESS: COPAYMENT	1,098.00
		REIMBURSEMENT	508,361.69
		ALL OTHER	430,302.34
		FEE SCHEDULE-LAB	684.71
		INJECTABLE DRUGS	77,374.64

TOTAL NUMBER OF CLAIMS 453

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,807.34	511.00	OTHER LAB	5,480.00	0.00
MED/SURG SUPPLY	83,081.84	1,232.16	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	86,373.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	148,669.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	36,951.00	11,008.00	FEE SCHEDULE LAB	11,823.00	0.00
EKG/ECG	1,118.00	0.00	MRI SERVICES	214,284.00	33,629.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	485,250.00	217,748.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	288,640.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	187,299.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	315,602.75	2,185.75
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,774.00	4,129.00	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	53,245.68	13,220.68
LITHOTRIPSY	39,761.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	65,652.00	3,047.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,764.00	161.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	10,613.00	1,980.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	401,305.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	191.33	0.00			
			TOTAL ANCILLARY	2,471,684.94	289,708.59
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,471,684.94	289,708.59

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: 08/24/2017
Run Time: 03:33:01
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	184,376.10	ADJUSTMENTS	0.00
COVERED CHARGES	179,382.85	CONTRACTUAL ALLOW	96,699.36
NON-COVERD CHARGES	4,993.25	TOTAL MEDICAID LIAB	82,683.49
		LESS: COB	82,664.54
		LESS: COPAYMENT	18.95
		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

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,841.50	300.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,315.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	912.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,886.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	676.00	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	54,847.00	3,917.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	32,064.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	23,974.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	30,888.75	100.25
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	26,654.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	179,382.85	4,993.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	179,382.85	4,993.25

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: 08/24/2017
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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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
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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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
Run Time: 03:33:01
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	277,906.82	ADJUSTMENTS	5,960.73
COVERED CHARGES	272,458.17	CONTRACTUAL ALLOW	230,712.06
NON-COVERD CHARGES	5,448.65	TOTAL MEDICAID LIAB	41,746.11
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	41,734.11

TOTAL NUMBER OF CLAIMS 7

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 07/01/15 THROUGH 06/30/16
 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	2,155.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,647.32	163.32	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,540.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	338.00	FEE SCHEDULE LAB	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	43,108.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	278.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	26,224.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,426.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	561.50	133.25
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	22,929.60	4,814.08
LITHOTRIPSY	152,588.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	272,458.17	5,448.65
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	272,458.17	5,448.65

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: 08/24/2017
Run Time: 03:33:01
Page: 12

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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
 Run Time: 02:35:08
 Page: 1

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,665,009.22	ADJUSTMENTS	744,449.09
COVERED CHARGES	11,572,652.22	CONTRACTUAL ALLOW	7,528,065.46
NON-COVERD CHARGES	92,357.00	TOTAL MEDICAID LIAB	4,044,586.76
		LESS: COB	14,569.27
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,030,017.49

TOTAL NUMBER OF ADMISSIONS 652

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,371		0	822,282.00		71,434.00
ROUTINE NURSERY	259		0	136,579.00		528.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		611.00
TOTAL ROUTINE	1,630		0	958,861.00		72,573.00
SPECIAL CARE SERVICES						
CCU	635		0	615,002.00		0.00
ICU	259		0	348,386.00		0.00
NICU	1		0	876.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	895		0	964,264.00		0.00
TOTAL ACCOMODATIONS	2,525		0	1,923,125.00		72,573.00

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,467,454.78	0.00	OTHER LAB	44,321.00	0.00
MED/SURG SUPPLY	838,819.83	338.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,549,842.00	0.00	EDUCATION & TRAINING	1,725.00	0.00
RADIOLOGY-DIAGNOSTIC	170,334.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	627,459.00	0.00	SPECIAL CHARGES	30,285.57	0.00
PHYSICAL THERAPY	70,543.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	75,104.00	0.00	MRI SERVICES	64,352.00	0.00
IV THERAPY	173,893.82	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	681,842.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	158,706.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,165,480.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	107,605.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	60,438.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	389,042.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	88,910.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	45,199.50	0.00	INJECTABLE DRUGS	585,920.72	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,676.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	11,253.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	65,743.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	181.00	12,474.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	600,708.00	0.00
LITHOTRIPSY	11,222.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	57,003.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	94,253.00	2,290.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	56,174.00	4,682.00			
AUDIOLOGY	15,096.00	0.00			
CARDIOLOGY	191,093.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,822.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	133,026.00	0.00			
			TOTAL ANCILLARY	9,649,527.22	19,784.00
			TOTAL ACCOMODATIONS	1,923,125.00	72,573.00
			TOTAL CHARGES	11,572,652.22	92,357.00

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

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

Run Date: 08/24/2017
 Run Time: 02:35:22
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	53,776.31	ADJUSTMENTS	0.00
COVERED CHARGES	52,997.31	CONTRACTUAL ALLOW	20,535.85
NON-COVERD CHARGES	779.00	TOTAL MEDICAID LIAB	32,461.46
		LESS: COB	32,461.46
		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	6,162.00		779.00
ROUTINE NURSERY	2		0	1,054.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	12		0	7,216.00		779.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1		0	1,346.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	1,346.00		0.00
TOTAL ACCOMODATIONS	13		0	8,562.00		779.00

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,996.42	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,612.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,767.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	985.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,642.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	662.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	390.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,964.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,701.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,887.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,026.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	596.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	327.00	0.00	INJECTABLE DRUGS	24.39	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	737.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	118.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	44,435.31	0.00
			TOTAL ACCOMODATIONS	8,562.00	779.00
			TOTAL CHARGES	52,997.31	779.00

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: 08/24/2017
Run Time: 02:35:23
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,426,408.11	ADJUSTMENTS	507,325.43
COVERED CHARGES	8,711,911.23	CONTRACTUAL ALLOW	6,662,639.78
NON-COVERD CHARGES	714,496.88	TOTAL MEDICAID LIAB	2,049,271.45
		LESS: COB	2,670.21
		LESS: COPAYMENT	6,494.85
		REIMBURSEMENT	2,040,106.39
		ALL OTHER	1,581,920.93
		FEE SCHEDULE-LAB	214,140.13
		INJECTABLE DRUGS	244,045.33

TOTAL NUMBER OF CLAIMS 5,571

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	287,236.83	2,663.59	OTHER LAB	63,129.00	263.00
MED/SURG SUPPLY	371,387.09	9,500.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	2,014.00	EDUCATION & TRAINING	0.00	405.00
RADIOLOGY-DIAGNOSTIC	318,674.70	2,146.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,267,392.00	148,837.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	31,835.00	9,877.02	FEE SCHEDULE LAB	990,846.00	58,133.00
EKG/ECG	100,140.00	892.00	MRI SERVICES	202,627.00	7,700.00
IV THERAPY	321,503.00	14,160.00	PROFESSIONAL FEES	0.00	401.00
OPERATING ROOM	730,889.16	39,217.83	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	168,574.00	52,352.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	124,442.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	199,282.33	21,511.67	CAST ROOM	0.00	0.00
EMERGENCY ROOM	928,575.00	15,494.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	89,051.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	7.50	INJECTABLE DRUGS	857,144.12	182,053.27
RADIOLOGY THERAPEUTIC	44,057.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	11,419.00	5,238.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,229.00	2,648.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,439.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	261,350.00	18,635.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	58,204.00	374.00
LITHOTRIPSY	11,222.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	208,336.00	12,483.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,670.00	6,957.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	352,381.00	57,392.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	347,587.00	33,743.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	96,788.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	252,940.00	4,960.00			
			TOTAL ANCILLARY	8,711,911.23	714,496.88
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,711,911.23	714,496.88

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

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

Run Date: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	139,742.76	ADJUSTMENTS	0.00
COVERED CHARGES	122,776.24	CONTRACTUAL ALLOW	39,515.30
NON-COVERD CHARGES	16,966.52	TOTAL MEDICAID LIAB	83,260.94
		LESS: COB	83,222.74
		LESS: COPAYMENT	38.20
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 109

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,989.46	22.68	OTHER LAB	2,095.00	0.00
MED/SURG SUPPLY	5,604.00	203.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	41.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,852.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,808.00	5,730.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	27,123.00	1,658.00
EKG/ECG	223.00	0.00	MRI SERVICES	2,064.00	2,831.00
IV THERAPY	3,847.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,281.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,732.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,833.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,337.00	1,321.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,784.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,122.78	227.84
RADIOLOGY THERAPEUTIC	188.00	188.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,297.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	248.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,892.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,653.00	741.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,491.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,145.00	1,170.00			
			TOTAL ANCILLARY	122,776.24	16,966.52
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	122,776.24	16,966.52

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: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	368,503.19	ADJUSTMENTS	1,129.74
COVERED CHARGES	355,587.02	CONTRACTUAL ALLOW	331,963.68
NON-COVERD CHARGES	12,916.17	TOTAL MEDICAID LIAB	23,623.34
		LESS: COB	0.00
		LESS: COPAYMENT	799.33
		REIMBURSEMENT	22,824.01
		TOTAL NUMBER OF CLAIMS	423

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,774.39	106.61	OTHER LAB	258.00	0.00
MED/SURG SUPPLY	12,445.00	20.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	141.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,814.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	73,250.00	6,235.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	38,249.00	3,308.00
EKG/ECG	5,342.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,659.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,241.00	138.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	162,461.00	1,322.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,049.63	100.56
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	178.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,236.00	1,545.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	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	0.00			
			TOTAL ANCILLARY	355,587.02	12,916.17
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	355,587.02	12,916.17

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

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,265.18	ADJUSTMENTS	0.00
COVERED CHARGES	5,734.18	CONTRACTUAL ALLOW	1,270.36
NON-COVERD CHARGES	531.00	TOTAL MEDICAID LIAB	4,463.82
		LESS: COB	4,443.84
		LESS: COPAYMENT	19.98
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	7

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	177.23	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	301.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	234.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,365.00	136.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	221.00	0.00	PROFESSIONAL FEES	0.00	395.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,325.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	110.95	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	5,734.18	531.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,734.18	531.00

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

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	661,505.71	ADJUSTMENTS	32,598.60
COVERED CHARGES	639,199.16	CONTRACTUAL ALLOW	503,040.52
NON-COVERD CHARGES	22,306.55	TOTAL MEDICAID LIAB	136,158.64
		LESS: COB	0.00
		LESS: COPAYMENT	171.00
		REIMBURSEMENT	135,987.64

TOTAL NUMBER OF CLAIMS 25

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,437.46	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	29,813.00	54.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,781.00	554.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,642.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,425.00	1,526.00
EKG/ECG	1,779.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,045.00	0.00	PROFESSIONAL FEES	0.00	24.00
OPERATING ROOM	24,497.72	1,426.28	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,648.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,651.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,676.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,941.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	460,625.98	13,821.27
RADIOLOGY THERAPEUTIC	16,455.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	629.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,071.00	464.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	10,114.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,698.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,156.00	2,949.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,981.00	859.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	12,922.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,840.00	0.00			
			TOTAL ANCILLARY	639,199.16	22,306.55
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	639,199.16	22,306.55

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

Run Date: 08/24/2017
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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	10/01/15	THROUGH	09/30/16
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: 08/24/2017
 Run Time: 04:14:14
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,682,515.02	ADJUSTMENTS	2,071,387.99
COVERED CHARGES	16,577,613.38	CONTRACTUAL ALLOW	9,868,704.22
NON-COVERD CHARGES	104,901.64	TOTAL MEDICAID LIAB	6,708,909.16
		LESS: COB	21,485.64
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,687,423.52

TOTAL NUMBER OF ADMISSIONS 1,382

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	8,440		0	9,308,965.00		10,738.00
ROUTINE NURSERY	102		0	71,400.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	8,542		0	9,380,365.00		10,738.00
SPECIAL CARE SERVICES						
CCU	214		0	374,500.00		0.00
ICU	166		0	452,350.00		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		38	0.00		41,800.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	380		38	826,850.00		41,800.00
TOTAL ACCOMODATIONS	8,922		38	10,207,215.00		52,538.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,333,758.35	0.00	OTHER LAB	36,055.00	0.00
MED/SURG SUPPLY	236,551.60	825.64	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,648,786.70	9,702.00	EDUCATION & TRAINING	3,150.00	175.00
RADIOLOGY-DIAGNOSTIC	92,432.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	329,003.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	44,862.81	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	68,203.00	0.00	MRI SERVICES	70,500.00	0.00
IV THERAPY	182,059.75	460.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	293,043.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	105,393.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	426,494.00	3,056.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	48,016.00	0.00	AMBULANCE	0.00	172.00
GI SERVICES	39,798.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	551,903.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,478.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	18,160.00	0.00	INJECTABLE DRUGS	177,306.69	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	8,756.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	33,516.00	13,524.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,005.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	10,285.00	IMPL DEV CHARGE PATIENTS	38,868.48	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	31,057.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	42,949.00	12,356.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	66,729.00	0.00			
AUDIOLOGY	3,250.00	0.00			
CARDIOLOGY	331,664.00	1,808.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,133.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	87,517.00	0.00			
			TOTAL ANCILLARY	6,370,398.38	52,363.64
			TOTAL ACCOMODATIONS	10,207,215.00	52,538.00
			TOTAL CHARGES	16,577,613.38	104,901.64

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

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

Run Date: 08/24/2017
 Run Time: 04:14:20
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	31,627.96	ADJUSTMENTS	0.00
COVERED CHARGES	31,627.96	CONTRACTUAL ALLOW	10,466.04
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	21,161.92
		LESS: COB	21,161.92
		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	0		0	0.00		0.00
ROUTINE NURSERY	2		0	1,400.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2		0	1,400.00		0.00
SPECIAL CARE SERVICES						
CCU	5		0	8,750.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	5		0	8,750.00		0.00
TOTAL ACCOMODATIONS	7		0	10,150.00		0.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,889.92	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,065.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,771.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	250.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,976.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	555.04	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	241.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	735.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	152.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,365.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,418.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	140.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	125.00	0.00			
CARDIOLOGY	1,795.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	21,477.96	0.00
			TOTAL ACCOMODATIONS	10,150.00	0.00
			TOTAL CHARGES	31,627.96	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: 08/24/2017
Run Time: 04:14:21
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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,914,412.92	ADJUSTMENTS	283,752.26
COVERED CHARGES	10,483,154.11	CONTRACTUAL ALLOW	7,614,961.91
NON-COVERD CHARGES	431,258.81	TOTAL MEDICAID LIAB	2,868,192.20
		LESS: COB	11,934.81
		LESS: COPAYMENT	5,316.00
		REIMBURSEMENT	2,850,941.39
		ALL OTHER	2,407,332.63
		FEE SCHEDULE-LAB	112,300.97
		INJECTABLE DRUGS	331,307.79
		TOTAL NUMBER OF CLAIMS	3,814

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	616,625.00	677.95	OTHER LAB	74,735.00	0.00
MED/SURG SUPPLY	56,778.91	304.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	2,261.00	EDUCATION & TRAINING	0.00	695.00
RADIOLOGY-DIAGNOSTIC	405,531.00	9,891.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,188,508.00	110,838.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,010.00	3,365.00	FEE SCHEDULE LAB	1,259,613.00	34,726.00
EKG/ECG	106,375.00	964.00	MRI SERVICES	275,556.00	3,236.00
IV THERAPY	717,187.00	11,890.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	488,074.50	114,712.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,250.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	95,470.00	4,695.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	154,029.00	1,381.00	AMBULANCE	0.00	0.00
GI SERVICES	164,033.00	16,651.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,991,950.00	6,371.36	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,362.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	608,915.95	13,773.00
RADIOLOGY THERAPEUTIC	1,210.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	994.00	1,491.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,932.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,185.00	3,099.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,205,980.00	29,870.00	IMPL DEV CHARGE PATIENTS	16,104.75	1,650.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	11,041.00
OTHER IMAGING SERVICE	222,813.00	20,914.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	19,714.00	800.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	234,852.00	9,570.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	241,569.00	13,185.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	155,763.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	149,966.00	1,275.00			
			TOTAL ANCILLARY	10,483,154.11	431,258.81
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,483,154.11	431,258.81

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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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015359025450	12/16/15 - 12/16/15	12/28/15	0.00	365.00	0.00	0.00	0.00
905	2015359025450	12/17/15 - 12/17/15	12/28/15	0.00	365.00	0.00	0.00	0.00
905	2216040008224	12/15/15 - 12/15/15	02/15/16	0.00	365.00	0.00	0.00	0.00
905	2216040008224	12/17/15 - 12/17/15	02/15/16	0.00	365.00	0.00	0.00	0.00
905	2216040008224	12/18/15 - 12/18/15	02/15/16	0.00	365.00	0.00	0.00	0.00
905	2216040008224	12/21/15 - 12/21/15	02/15/16	0.00	365.00	0.00	0.00	0.00
905	2216040008224	12/22/15 - 12/22/15	02/15/16	0.00	365.00	0.00	0.00	0.00
905	2216067002881	01/18/16 - 01/18/16	03/14/16	0.00	365.00	0.00	0.00	0.00
905	2216067002881	01/19/16 - 01/19/16	03/14/16	0.00	365.00	0.00	0.00	0.00
905	2216067002881	01/20/16 - 01/20/16	03/14/16	0.00	365.00	0.00	0.00	0.00
905	2216067002881	01/21/16 - 01/21/16	03/14/16	0.00	365.00	0.00	0.00	0.00
905	2216067002881	01/25/16 - 01/25/16	03/14/16	0.00	365.00	0.00	0.00	0.00
905	2216067002881	01/26/16 - 01/26/16	03/14/16	0.00	365.00	0.00	0.00	0.00
905	2216067002881	01/27/16 - 01/27/16	03/14/16	0.00	365.00	0.00	0.00	0.00
905	2216067002881	01/28/16 - 01/28/16	03/14/16	0.00	365.00	0.00	0.00	0.00
905	2216067002881	01/29/16 - 01/29/16	03/14/16	0.00	365.00	0.00	0.00	0.00
905	2216067002881	02/01/16 - 02/01/16	03/14/16	0.00	365.00	0.00	0.00	0.00
905	2016239078638	08/01/16 - 08/01/16	08/29/16	0.00	372.00	0.00	0.00	0.00
905	2016239078638	08/02/16 - 08/02/16	08/29/16	0.00	372.00	0.00	0.00	0.00
905	2016239078638	08/03/16 - 08/03/16	08/29/16	0.00	372.00	0.00	0.00	0.00
905	2016239078638	08/04/16 - 08/04/16	08/29/16	0.00	372.00	0.00	0.00	0.00
905	2016239078638	08/05/16 - 08/05/16	08/29/16	0.00	372.00	0.00	0.00	0.00
905	2016239078638	08/08/16 - 08/08/16	08/29/16	0.00	372.00	0.00	0.00	0.00
905	2016239078638	08/09/16 - 08/09/16	08/29/16	0.00	372.00	0.00	0.00	0.00
905	2016239078638	08/10/16 - 08/10/16	08/29/16	0.00	372.00	0.00	0.00	0.00
905	2016239078638	08/11/16 - 08/11/16	08/29/16	0.00	372.00	0.00	0.00	0.00
905	2016239078638	08/12/16 - 08/12/16	08/29/16	0.00	372.00	0.00	0.00	0.00
905	2016239078638	08/15/16 - 08/15/16	08/29/16	0.00	372.00	0.00	0.00	0.00
905	2016239078638	08/16/16 - 08/16/16	08/29/16	0.00	372.00	0.00	0.00	0.00
905	2016239078638	08/17/16 - 08/17/16	08/29/16	0.00	372.00	0.00	0.00	0.00
TOTAL				0.00	11,041.00	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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	207,039.47	ADJUSTMENTS	0.00
COVERED CHARGES	101,680.54	CONTRACTUAL ALLOW	-18,416.89
NON-COVERD CHARGES	105,358.93	TOTAL MEDICAID LIAB	120,097.43
		LESS: COB	120,052.43
		LESS: COPAYMENT	45.00
		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

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,740.04	550.80	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	389.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,184.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	17,800.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,219.00	570.00
EKG/ECG	1,205.00	0.00	MRI SERVICES	0.00	3,584.00
IV THERAPY	8,660.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,200.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	840.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,352.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	24,371.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	750.00	57,395.13
RADIOLOGY THERAPEUTIC	1,210.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	32,670.00	7,865.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	5,110.00
OTHER IMAGING SERVICE	450.00	550.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	5,110.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,632.00	3,590.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	160.00	882.00			
			TOTAL ANCILLARY	101,680.54	105,358.93
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	101,680.54	105,358.93

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015271019731	08/10/15 - 08/10/15	10/05/15	0.00	365.00	0.00	7,538.73	0.00
905	2015271019731	08/11/15 - 08/11/15	10/05/15	0.00	365.00	0.00	7,538.73	0.00
905	2015271019731	08/12/15 - 08/12/15	10/05/15	0.00	365.00	0.00	7,538.73	0.00
905	2015271019731	08/13/15 - 08/13/15	10/05/15	0.00	365.00	0.00	7,538.73	0.00
905	2015271019731	08/14/15 - 08/14/15	10/05/15	0.00	365.00	0.00	7,538.73	0.00
905	2015271019731	08/17/15 - 08/17/15	10/05/15	0.00	365.00	0.00	7,538.73	0.00
905	2015271019731	08/18/15 - 08/18/15	10/05/15	0.00	365.00	0.00	7,538.73	0.00
905	2015271019731	08/19/15 - 08/19/15	10/05/15	0.00	365.00	0.00	7,538.73	0.00
905	2015271019731	08/20/15 - 08/20/15	10/05/15	0.00	365.00	0.00	7,538.73	0.00
905	2015271019731	08/21/15 - 08/21/15	10/05/15	0.00	365.00	0.00	7,538.73	0.00
905	2016279066664	05/06/16 - 05/06/16	10/10/16	0.00	365.00	0.00	9,187.72	0.00
905	2016279066664	05/10/16 - 05/10/16	10/10/16	0.00	365.00	0.00	9,187.72	0.00
905	2016279066664	05/11/16 - 05/11/16	10/10/16	0.00	365.00	0.00	9,187.72	0.00
905	2016279066664	05/09/16 - 05/09/16	10/10/16	0.00	365.00	0.00	9,187.72	0.00
TOTAL				0.00	5,110.00	0.00	112,138.18	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: 08/24/2017
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Page: 11

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	567,699.22	ADJUSTMENTS	379.58
COVERED CHARGES	554,564.61	CONTRACTUAL ALLOW	530,006.95
NON-COVERD CHARGES	13,134.61	TOTAL MEDICAID LIAB	24,557.66
		LESS: COB	0.00
		LESS: COPAYMENT	783.36
		REIMBURSEMENT	23,774.30
		TOTAL NUMBER OF CLAIMS	439

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,373.20	0.00	OTHER LAB	2,532.00	0.00
MED/SURG SUPPLY	868.74	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	255.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,133.00	912.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	64,742.00	4,550.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	555.00	0.00	FEE SCHEDULE LAB	85,323.00	1,694.00
EKG/ECG	4,338.00	0.00	MRI SERVICES	13,427.00	0.00
IV THERAPY	44,255.00	505.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,293.00	4,293.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,600.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,257.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	281,974.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	223.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,633.67	375.61
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,525.00	550.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,512.00	0.00			
			TOTAL ANCILLARY	554,564.61	13,134.61
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	554,564.61	13,134.61

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,783.61	ADJUSTMENTS	0.00
COVERED CHARGES	18,987.00	CONTRACTUAL ALLOW	15,853.40
NON-COVERD CHARGES	796.61	TOTAL MEDICAID LIAB	3,133.60
		LESS: COB	3,118.60
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	501.00	276.61	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	83.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,493.00	228.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,550.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,673.00	292.00
EKG/ECG	241.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,205.00	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	6,220.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	21.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	18,987.00	796.61
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,987.00	796.61

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

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,270,579.61	ADJUSTMENTS	54,757.65
COVERED CHARGES	1,241,872.75	CONTRACTUAL ALLOW	865,512.99
NON-COVERD CHARGES	28,706.86	TOTAL MEDICAID LIAB	376,359.76
		LESS: COB	10,812.15
		LESS: COPAYMENT	234.00
		REIMBURSEMENT	365,313.61
		TOTAL NUMBER OF CLAIMS	66

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	72,821.89	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	46,136.48	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,203.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,022.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	36,025.00	1,082.00
EKG/ECG	3,615.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	85,555.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	232,543.50	8,916.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,800.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	31,647.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,610.00	2,352.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,443.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,446.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	447,510.36	3,751.36
RADIOLOGY THERAPEUTIC	1,815.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	140.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	39,930.00	0.00	IMPL DEV CHARGE PATIENTS	108,300.52	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	450.00	1,100.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,888.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,266.00	9,570.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	58,921.00	1,795.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	21,924.00	0.00			
			TOTAL ANCILLARY	1,241,872.75	28,706.86
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,241,872.75	28,706.86

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

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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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	207,220.91	ADJUSTMENTS	47,029.66
COVERED CHARGES	205,922.41	CONTRACTUAL ALLOW	120,146.91
NON-COVERD CHARGES	1,298.50	TOTAL MEDICAID LIAB	85,775.50
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	85,775.50

TOTAL NUMBER OF ADMISSIONS 17

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	28		0	7,633.50		400.75
ROUTINE NURSERY	0		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	7,633.50		400.75
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	18		0	18,909.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	18,909.00		0.00
TOTAL ACCOMODATIONS	46		0	26,542.50		400.75

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

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

Run Date: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	40,171.55	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	16,296.29	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	40,685.06	0.00	EDUCATION & TRAINING	344.00	0.00
RADIOLOGY-DIAGNOSTIC	4,136.50	0.00	OTHER THERAPEUTIC SVC	0.00	897.75
CT SCAN	5,705.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	256.25	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,923.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	13,312.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,597.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,175.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	771.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,418.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	945.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,430.61	0.00	INJECTABLE DRUGS	8,640.40	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	103.75	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	700.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,100.00	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	2,931.00	0.00			
			TOTAL ANCILLARY	179,379.91	897.75
			TOTAL ACCOMODATIONS	26,542.50	400.75
			TOTAL CHARGES	205,922.41	1,298.50

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

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

Run Date: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
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: 08/24/2017
Run Time: 03:52:19
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,103,321.86	ADJUSTMENTS	16,859.66
COVERED CHARGES	1,062,724.97	CONTRACTUAL ALLOW	844,797.16
NON-COVERD CHARGES	40,596.89	TOTAL MEDICAID LIAB	217,927.81
		LESS: COB	0.00
		LESS: COPAYMENT	873.00
		REIMBURSEMENT	217,054.81
		ALL OTHER	186,618.45
		FEE SCHEDULE-LAB	29,746.60
		INJECTABLE DRUGS	689.76

TOTAL NUMBER OF CLAIMS 852

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: 08/24/2017
 Run Time: 03:52:19
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57,597.21	821.70	OTHER LAB	4,857.00	0.00
MED/SURG SUPPLY	63,886.22	111.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	711.13	EDUCATION & TRAINING	0.00	559.00
RADIOLOGY-DIAGNOSTIC	69,647.75	290.50	OTHER THERAPEUTIC SVC	0.00	2,992.50
CT SCAN	51,451.00	2,379.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	183,212.15	16,562.87
EKG/ECG	35,908.00	0.00	MRI SERVICES	12,874.50	0.00
IV THERAPY	36,015.00	1,551.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	105,273.75	4,851.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,198.00	2,177.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	54,075.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	231,157.00	66.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	39,532.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	68.79	INJECTABLE DRUGS	16,393.80	3,860.20
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	17,552.34	1,474.75	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	10,178.00	326.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,575.00	678.70			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	13,872.50	948.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,714.75	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	19,424.25	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	16,329.25	166.00			
			TOTAL ANCILLARY	1,062,724.97	40,596.89
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,062,724.97	40,596.89

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,551.68	ADJUSTMENTS	0.00
COVERED CHARGES	9,312.08	CONTRACTUAL ALLOW	3,296.59
NON-COVERD CHARGES	5,239.60	TOTAL MEDICAID LIAB	6,015.49
		LESS: COB	5,991.49
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 12

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

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	298.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	858.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,005.38	17.25
EKG/ECG	180.85	0.00	MRI SERVICES	896.25	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	5,040.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,585.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	945.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	68.20
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	314.85	114.15	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	326.25	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	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	164.75	0.00			
			TOTAL ANCILLARY	9,312.08	5,239.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,312.08	5,239.60

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	106,304.80	ADJUSTMENTS	108.88
COVERED CHARGES	104,728.97	CONTRACTUAL ALLOW	98,128.05
NON-COVERD CHARGES	1,575.83	TOTAL MEDICAID LIAB	6,600.92
		LESS: COB	50.00
		LESS: COPAYMENT	222.00
		REIMBURSEMENT	6,328.92
		TOTAL NUMBER OF CLAIMS	118

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,935.40	0.00	OTHER LAB	1,576.75	0.00
MED/SURG SUPPLY	1,669.25	240.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,045.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,805.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,831.17	1,070.13
EKG/ECG	2,579.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,910.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	985.50	31.50	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	68,491.50	89.25	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	899.40	144.20
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	104,728.97	1,575.83
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	104,728.97	1,575.83

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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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,470.43	ADJUSTMENTS	0.00
COVERED CHARGES	1,470.43	CONTRACTUAL ALLOW	795.67
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	674.76
		LESS: COB	674.76
		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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 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	14.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	458.93	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,470.43	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,470.43	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

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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
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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	07/01/15	THROUGH	06/30/16
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

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,619,377.00	ADJUSTMENTS	493,498.06
COVERED CHARGES	5,572,028.00	CONTRACTUAL ALLOW	3,742,666.83
NON-COVERD CHARGES	47,349.00	TOTAL MEDICAID LIAB	1,829,361.17
		LESS: COB	34,916.84
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,794,444.33

TOTAL NUMBER OF ADMISSIONS 236

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	711		0	364,743.00		39,571.00
ROUTINE NURSERY	57		0	19,152.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	768		0	383,895.00		39,571.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	171		0	225,891.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	225,891.00		0.00
TOTAL ACCOMODATIONS	939		0	609,786.00		39,571.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,199,054.40	0.00	OTHER LAB	28,830.00	0.00
MED/SURG SUPPLY	1,020,262.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	764,138.12	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	82,755.00	0.00	OTHER THERAPEUTIC SVC	0.00	9.00
CT SCAN	286,888.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	48,378.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	26,560.00	0.00	MRI SERVICES	36,580.00	0.00
IV THERAPY	84,886.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	578,763.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	21,226.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	181,375.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	73,120.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	95,563.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	33,956.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,746.00	0.00	INJECTABLE DRUGS	8,456.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,408.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,014.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	9,135.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	6,793.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	77,996.00	0.00
LITHOTRIPSY	20,418.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	21,897.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	33,932.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	18,556.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	65,652.00	0.00			
AMBULATORY SURGERY	6,165.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	126,532.48	976.00			
			TOTAL ANCILLARY	4,962,242.00	7,778.00
			TOTAL ACCOMODATIONS	609,786.00	39,571.00
			TOTAL CHARGES	5,572,028.00	47,349.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,374.00	ADJUSTMENTS	0.00
COVERED CHARGES	7,262.00	CONTRACTUAL ALLOW	2,107.57
NON-COVERD CHARGES	112.00	TOTAL MEDICAID LIAB	5,154.43
		LESS: COB	5,154.43
		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	1,026.00		112.00
ROUTINE NURSERY	0		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	1,026.00		112.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	1,026.00		112.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	803.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,032.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	814.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	111.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,476.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,236.00	0.00
			TOTAL ACCOMODATIONS	1,026.00	112.00
			TOTAL CHARGES	7,262.00	112.00

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,971,874.23	ADJUSTMENTS	327,836.94
COVERED CHARGES	5,335,088.57	CONTRACTUAL ALLOW	4,110,066.31
NON-COVERD CHARGES	636,785.66	TOTAL MEDICAID LIAB	1,225,022.26
		LESS: COB	4,328.76
		LESS: COPAYMENT	2,938.02
		REIMBURSEMENT	1,217,755.48
		ALL OTHER	1,091,434.30
		FEE SCHEDULE-LAB	105,100.27
		INJECTABLE DRUGS	21,220.91

TOTAL NUMBER OF CLAIMS 2,930

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	360,654.75	1,675.00	OTHER LAB	29,090.00	0.00
MED/SURG SUPPLY	626,639.39	5,385.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	223,623.00	4,615.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	715,423.00	147,005.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,029.00	6,577.00	FEE SCHEDULE LAB	964,631.00	84,521.00
EKG/ECG	71,024.00	4,480.00	MRI SERVICES	121,438.00	24,358.00
IV THERAPY	171,004.00	56,922.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	441,823.00	21,820.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	13,642.00	846.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	67,781.00	6,676.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	68,175.00	530.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	633,195.00	6,056.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	34,398.00	533.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	184,932.25	187,351.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,410.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	2,118.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	40,100.00	347.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	3,456.00
LITHOTRIPSY	104,262.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	104,868.00	18,662.00			
BLOOD	638.00	0.00			
BLOOD STORAGE & PRO.	2,089.00	2,143.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	86,704.00	7,149.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	69,216.00	28,451.00			
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	198,709.18	12,699.16			
			TOTAL ANCILLARY	5,335,088.57	636,785.66
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,335,088.57	636,785.66

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

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	109,474.00	ADJUSTMENTS	0.00
COVERED CHARGES	90,301.00	CONTRACTUAL ALLOW	37,818.84
NON-COVERD CHARGES	19,173.00	TOTAL MEDICAID LIAB	52,482.16
		LESS: COB	52,458.16
		LESS: COPAYMENT	24.00
		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

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,098.00	0.00	OTHER LAB	1,512.00	0.00
MED/SURG SUPPLY	13,919.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,072.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,732.00	15,629.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	15,357.00	1,362.00
EKG/ECG	640.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,762.00	813.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,825.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	159.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,150.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,634.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	884.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,786.00	1,369.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,196.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,880.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,695.00	0.00			
			TOTAL ANCILLARY	90,301.00	19,173.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	90,301.00	19,173.00

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	833,249.56	ADJUSTMENTS	2,926.86
COVERED CHARGES	756,844.06	CONTRACTUAL ALLOW	718,692.98
NON-COVERD CHARGES	76,405.50	TOTAL MEDICAID LIAB	38,151.08
		LESS: COB	85.69
		LESS: COPAYMENT	1,314.90
		REIMBURSEMENT	36,750.49
		TOTAL NUMBER OF CLAIMS	682

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

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48,132.00	0.00	OTHER LAB	2,268.00	0.00
MED/SURG SUPPLY	35,877.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	33,393.00	221.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	133,495.00	40,573.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	148,671.00	13,267.00
EKG/ECG	6,400.00	160.00	MRI SERVICES	0.00	0.00
IV THERAPY	43,529.00	8,922.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,154.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	477.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,430.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	225,934.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,118.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	43,203.00	5,668.50
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	17,799.00	6,956.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,156.00	638.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,808.06	0.00			
			TOTAL ANCILLARY	756,844.06	76,405.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	756,844.06	76,405.50

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

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,272.00	ADJUSTMENTS	0.00
COVERED CHARGES	9,318.00	CONTRACTUAL ALLOW	3,733.82
NON-COVERD CHARGES	1,954.00	TOTAL MEDICAID LIAB	5,584.18
		LESS: COB	5,566.18
		LESS: COPAYMENT	18.00
		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

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,084.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	194.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	278.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,878.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,130.00	76.00
EKG/ECG	320.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	449.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,740.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	123.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,318.00	1,954.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,318.00	1,954.00

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	559,476.00	ADJUSTMENTS	17,633.49
COVERED CHARGES	540,803.00	CONTRACTUAL ALLOW	423,319.84
NON-COVERD CHARGES	18,673.00	TOTAL MEDICAID LIAB	117,483.16
		LESS: COB	0.00
		LESS: COPAYMENT	105.00
		REIMBURSEMENT	117,378.16
		TOTAL NUMBER OF CLAIMS	20

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,305.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	132,457.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,995.00	630.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	5,622.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,041.00	FEE SCHEDULE LAB	8,829.00	501.00
EKG/ECG	1,760.00	320.00	MRI SERVICES	0.00	0.00
IV THERAPY	585.00	275.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	94,383.00	6,638.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,009.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	17,040.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	414.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,170.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,390.00	2,830.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	277.00
LITHOTRIPSY	233,954.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	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	512.00	0.00			
			TOTAL ANCILLARY	540,803.00	18,673.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	540,803.00	18,673.00

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: 08/24/2017
Run Time: 04:21:40
Page: 15

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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
 Run Time: 04:21:49
 Page: 1

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

WELLSTAR WEST GEORGIA MEDICAL CENTER
 1514 VERNON RD
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER 000002065A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,896,378.97	ADJUSTMENTS	682,904.94
COVERED CHARGES	8,872,388.64	CONTRACTUAL ALLOW	5,562,764.88
NON-COVERD CHARGES	23,990.33	TOTAL MEDICAID LIAB	3,309,623.76
		LESS: COB	27,635.95
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,281,987.81

TOTAL NUMBER OF ADMISSIONS 438

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	860		0	804,100.00		1,870.00
ROUTINE NURSERY	161		0	109,515.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,021		0	913,615.00		1,870.00
SPECIAL CARE SERVICES						
CCU	502		0	792,640.00		0.00
ICU	187		0	390,100.00		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	689		0	1,182,740.00		0.00
TOTAL ACCOMODATIONS	1,710		0	2,096,355.00		1,870.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

WELLSTAR WEST GEORGIA MEDICAL CENTER
 1514 VERNON RD
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	939,898.66	0.00	OTHER LAB	28,793.50	0.00
MED/SURG SUPPLY	361,626.48	1,741.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,186,140.05	0.00	EDUCATION & TRAINING	4,428.00	0.00
RADIOLOGY-DIAGNOSTIC	163,620.45	0.00	OTHER THERAPEUTIC SVC	0.00	312.00
CT SCAN	377,395.30	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	52,837.87	0.13	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	160,633.00	0.00	MRI SERVICES	63,550.00	0.00
IV THERAPY	8,682.55	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	975,937.65	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	161,573.10	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	372,762.15	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	235,685.60	0.00	AMBULANCE	0.00	0.00
GI SERVICES	54,103.85	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	564,265.90	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	76,827.55	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	65,007.40	0.00	INJECTABLE DRUGS	403.75	0.00
RADIOLOGY THERAPEUTIC	1,392.95	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,752.30	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	41,860.50	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,403.35	262.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	235,869.13	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	59,192.10	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	71,445.15	16,881.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	59,386.00	2,924.20			
AUDIOLOGY	6,600.00	0.00			
CARDIOLOGY	425,753.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,844.10	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,362.25	0.00			
			TOTAL ANCILLARY	6,776,033.64	22,120.33
			TOTAL ACCOMODATIONS	2,096,355.00	1,870.00
			TOTAL CHARGES	8,872,388.64	23,990.33

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

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

Run Date: 08/24/2017
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SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR WEST GEORGIA MEDICAL CENTER
 1514 VERNON RD
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	73,163.20	ADJUSTMENTS	0.00
COVERED CHARGES	73,163.20	CONTRACTUAL ALLOW	23,819.05
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	49,344.15
		LESS: COB	49,344.15
		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	13		0	12,155.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	13		0	12,155.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	2		0	4,150.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2		0	4,150.00		0.00
TOTAL ACCOMODATIONS	15		0	16,305.00		0.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR WEST GEORGIA MEDICAL CENTER
 1514 VERNON RD
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,383.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	837.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,528.60	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	446.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,031.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,396.05	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	23,081.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	290.60	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,515.95	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,325.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	761.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,050.00	0.00	INJECTABLE DRUGS	211.75	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	56,858.20	0.00
			TOTAL ACCOMODATIONS	16,305.00	0.00
			TOTAL CHARGES	73,163.20	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: 08/24/2017
Run Time: 04:21:55
Page: 5

WELLSTAR WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,772,307.34	ADJUSTMENTS	392,250.89
COVERED CHARGES	10,664,916.30	CONTRACTUAL ALLOW	8,656,755.44
NON-COVERD CHARGES	1,107,391.04	TOTAL MEDICAID LIAB	2,008,160.86
		LESS: COB	5,867.00
		LESS: COPAYMENT	4,546.02
		REIMBURSEMENT	1,997,747.84
		ALL OTHER	1,744,004.59
		FEE SCHEDULE-LAB	184,665.67
		INJECTABLE DRUGS	69,077.58

TOTAL NUMBER OF CLAIMS 5,330

WELLSTAR WEST GEORGIA MEDICAL CENTER
 1514 VERNON RD
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	235,819.11	194.50	OTHER LAB	95,088.65	0.00
MED/SURG SUPPLY	243,030.77	62,083.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	996.00
RADIOLOGY-DIAGNOSTIC	401,708.10	10,523.70	OTHER THERAPEUTIC SVC	0.00	346.00
CT SCAN	718,136.40	124,134.45	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	13,229.00	2,506.13	FEE SCHEDULE LAB	1,787,879.66	126,126.65
EKG/ECG	201,977.89	24,234.36	MRI SERVICES	66,100.00	2,621.50
IV THERAPY	208,641.90	8,612.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,190,130.38	128,967.07	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	33,315.90	435.00	REHAB THERAPY	0.00	2,100.00
RESPIRATORY SERVICES	425,223.05	57,993.35	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	403,361.35	1,707.05	AMBULANCE	0.00	0.00
GI SERVICES	173,306.80	33,203.65	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,853,497.10	58,058.40	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	170,712.70	1,103.90	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	209,763.71	49,252.43
RADIOLOGY THERAPEUTIC	290,035.10	240,945.70	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,301.00	852.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	430.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	709.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,386.35	1,011.70	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	259,864.30	36,478.20			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	21,444.20	1,986.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	90,964.00	50,612.05			
AUDIOLOGY	1,246.85	0.00			
CARDIOLOGY	245,944.20	71,841.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,229.40	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	310,578.43	7,325.00			
			TOTAL ANCILLARY	10,664,916.30	1,107,391.04
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,664,916.30	1,107,391.04

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: 08/24/2017
Run Time: 04:22:15
Page: 7

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	186,156.95	ADJUSTMENTS	0.00
COVERED CHARGES	159,741.45	CONTRACTUAL ALLOW	46,964.05
NON-COVERD CHARGES	26,415.50	TOTAL MEDICAID LIAB	112,777.40
		LESS: COB	112,743.10
		LESS: COPAYMENT	34.30
		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

WELLSTAR WEST GEORGIA MEDICAL CENTER
 1514 VERNON RD
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,172.95	0.00	OTHER LAB	656.75	0.00
MED/SURG SUPPLY	4,114.15	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,107.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	6,800.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	32,106.45	1,556.40
EKG/ECG	2,406.25	343.75	MRI SERVICES	2,500.00	0.00
IV THERAPY	6,805.20	370.40	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	28,202.65	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,010.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,354.60	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,287.65	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	41,574.25	248.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,509.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,251.55	12,656.75
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	101.95	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	280.75
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,026.20	4,057.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,656.20	0.00			
			TOTAL ANCILLARY	159,741.45	26,415.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	159,741.45	26,415.50

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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WELLSTAR WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	641,879.85	ADJUSTMENTS	582.39
COVERED CHARGES	627,525.70	CONTRACTUAL ALLOW	598,604.72
NON-COVERD CHARGES	14,354.15	TOTAL MEDICAID LIAB	28,920.98
		LESS: COB	0.00
		LESS: COPAYMENT	908.43
		REIMBURSEMENT	28,012.55
		TOTAL NUMBER OF CLAIMS	517

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

WELLSTAR WEST GEORGIA MEDICAL CENTER
 1514 VERNON RD
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,372.80	0.00	OTHER LAB	656.75	0.00
MED/SURG SUPPLY	1,801.70	98.45	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,985.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	46,250.00	4,800.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	97,206.05	3,276.70
EKG/ECG	10,312.50	343.75	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	3,599.55	1,515.60	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	412,424.55	2,307.35	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	3,307.05	264.90
RADIOLOGY THERAPEUTIC	2,275.20	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	70.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,182.80	1,032.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,785.00	715.40			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	810.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,486.50	0.00			
			TOTAL ANCILLARY	627,525.70	14,354.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	627,525.70	14,354.15

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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WELLSTAR WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,455.60	ADJUSTMENTS	0.00
COVERED CHARGES	25,325.30	CONTRACTUAL ALLOW	19,909.60
NON-COVERD CHARGES	1,130.30	TOTAL MEDICAID LIAB	5,415.70
		LESS: COB	5,396.70
		LESS: COPAYMENT	19.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	11

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR WEST GEORGIA MEDICAL CENTER
 1514 VERNON RD
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	698.55	6.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	78.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	548.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,800.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,072.75	337.80
EKG/ECG	0.00	343.75	MRI SERVICES	0.00	0.00
IV THERAPY	4,556.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,565.65	248.50	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	1,005.75	93.75
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	100.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	25,325.30	1,130.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,325.30	1,130.30

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

WELLSTAR WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	965,749.29	ADJUSTMENTS	38,705.61
COVERED CHARGES	841,179.58	CONTRACTUAL ALLOW	680,761.61
NON-COVERD CHARGES	124,569.71	TOTAL MEDICAID LIAB	160,417.97
		LESS: COB	26,494.60
		LESS: COPAYMENT	255.45
		REIMBURSEMENT	133,667.92

TOTAL NUMBER OF CLAIMS 26

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

WELLSTAR WEST GEORGIA MEDICAL CENTER
 1514 VERNON RD
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,157.18	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	49,313.92	21,301.15	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	36.00
RADIOLOGY-DIAGNOSTIC	6,901.25	1,164.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,517.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	420.00	0.02	FEE SCHEDULE LAB	22,160.15	1,622.40
EKG/ECG	3,093.75	343.75	MRI SERVICES	2,500.00	5,000.00
IV THERAPY	50,377.50	3,233.65	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	121,253.51	17,539.89	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	757.80	378.90	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	25,341.35	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,298.50	1,236.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,403.30	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	190,368.87	4,312.25
RADIOLOGY THERAPEUTIC	187,698.50	59,604.75	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	2,468.35	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,973.60	6,584.15			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,692.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,097.00	2,212.80			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	109,781.20	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	7,604.85	0.00			
			TOTAL ANCILLARY	841,179.58	124,569.71
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	841,179.58	124,569.71

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

WELLSTAR WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	28,699.40	ADJUSTMENTS	0.00
COVERED CHARGES	24,175.90	CONTRACTUAL ALLOW	6,295.79
NON-COVERD CHARGES	4,523.50	TOTAL MEDICAID LIAB	17,880.11
		LESS: COB	17,871.11
		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

WELLSTAR WEST GEORGIA MEDICAL CENTER
 1514 VERNON RD
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	349.56	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	83.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,500.00	4,200.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,848.00	185.20	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	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,394.94	138.30
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	24,175.90	4,523.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	24,175.90	4,523.50

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

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

PROVIDER NUMBER 000002087A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	332,379.00	ADJUSTMENTS	62,928.54
COVERED CHARGES	319,503.00	CONTRACTUAL ALLOW	137,858.87
NON-COVERD CHARGES	12,876.00	TOTAL MEDICAID LIAB	181,644.13
		LESS: COB	6,554.84
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	175,089.29

TOTAL NUMBER OF ADMISSIONS 32

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	114		0	55,740.00		9,915.00
ROUTINE NURSERY	0		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	55,740.00		9,915.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	55,740.00		9,915.00

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 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	62,038.00	0.00	OTHER LAB	2,278.00	0.00
MED/SURG SUPPLY	31,012.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	27,097.00	49.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,227.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,842.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,523.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,140.00	0.00	MRI SERVICES	2,465.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	63,268.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	26,969.00	0.00	SPECIAL SERVICES	0.00	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	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,280.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	17.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,424.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,130.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,013.00	2,895.00			
			TOTAL ANCILLARY	263,763.00	2,961.00
			TOTAL ACCOMODATIONS	55,740.00	9,915.00
			TOTAL CHARGES	319,503.00	12,876.00

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

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

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/15 THROUGH 04/30/16
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 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	692,687.00	ADJUSTMENTS	26,007.87
COVERED CHARGES	565,814.00	CONTRACTUAL ALLOW	262,926.46
NON-COVERD CHARGES	126,873.00	TOTAL MEDICAID LIAB	302,887.54
		LESS: COB	639.20
		LESS: COPAYMENT	976.15
		REIMBURSEMENT	301,272.19
		ALL OTHER	279,201.02
		FEE SCHEDULE-LAB	21,161.18
		INJECTABLE DRUGS	909.99

TOTAL NUMBER OF CLAIMS 780

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

PROVIDER NUMBER
 000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,594.00	337.00	OTHER LAB	6,123.00	0.00
MED/SURG SUPPLY	15,623.00	47.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	435.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,074.00	1,540.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	69,479.00	7,993.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,697.00	3,748.00	FEE SCHEDULE LAB	120,230.00	10,312.00
EKG/ECG	8,503.00	305.00	MRI SERVICES	13,117.00	2,465.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	19,531.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	33,459.00	21,006.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	173,652.00	57,204.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,620.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,446.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	37.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	2.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	88.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	479.00
OTHER IMAGING SERVICE	7,272.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	140.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,007.00	8,939.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,176.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,983.00	12,024.00			
			TOTAL ANCILLARY	565,814.00	126,873.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	565,814.00	126,873.00

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 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
285	2215152003941	05/23/15 - 05/23/15	06/08/15	0.00	165.00	0.00	0.00	0.00
10	2215343008246	08/27/15 - 08/27/15	12/14/15	0.00	314.00	0.00	0.00	0.00
TOTAL				0.00	479.00	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 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,380.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,440.00	CONTRACTUAL ALLOW	-1,347.07
NON-COVERD CHARGES	3,940.00	TOTAL MEDICAID LIAB	2,787.07
		LESS: COB	2,778.07
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

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 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	445.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	253.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	124.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	146.00	0.00
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	2,815.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	262.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	389.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	736.00			
			TOTAL ANCILLARY	1,440.00	3,940.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,440.00	3,940.00

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

PROVIDER NUMBER
000002087A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	63,803.00	ADJUSTMENTS	191.00
COVERED CHARGES	61,843.00	CONTRACTUAL ALLOW	56,618.00
NON-COVERD CHARGES	1,960.00	TOTAL MEDICAID LIAB	5,225.00
		LESS: COB	0.00
		LESS: COPAYMENT	213.00
		REIMBURSEMENT	5,012.00
		TOTAL NUMBER OF CLAIMS	105

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

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

PROVIDER NUMBER
 000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,170.00	30.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	735.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	103.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,473.00	173.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,835.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,731.00	554.00
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	45,614.00	1,012.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	289.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	891.00	88.00			
			TOTAL ANCILLARY	61,843.00	1,960.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	61,843.00	1,960.00

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

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

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	202.00	ADJUSTMENTS	0.00
COVERED CHARGES	202.00	CONTRACTUAL ALLOW	126.25
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	75.75
		LESS: COB	75.75
		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

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

PROVIDER NUMBER
 000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 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	202.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	202.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	202.00	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: 08/24/2017
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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 05/01/15 THROUGH 04/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,119.00	ADJUSTMENTS	0.00
COVERED CHARGES	25,341.00	CONTRACTUAL ALLOW	15,486.95
NON-COVERD CHARGES	1,778.00	TOTAL MEDICAID LIAB	9,854.05
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	9,851.05
		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: 08/24/2017
 Run Time: 04:22:41
 Page: 14

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 05/01/15 THROUGH 04/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,746.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,962.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	173.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	633.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	530.00	14.00
EKG/ECG	95.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,300.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	1,200.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,295.00	212.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	262.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	345.00	352.00			
			TOTAL ANCILLARY	25,341.00	1,778.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,341.00	1,778.00

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: 08/24/2017
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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	05/01/15	THROUGH	04/30/16
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: 08/24/2017
 Run Time: 02:07:40
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000002098A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,507,028.22	ADJUSTMENTS	132,977.38
COVERED CHARGES	6,276,090.66	CONTRACTUAL ALLOW	5,029,356.51
NON-COVERD CHARGES	230,937.56	TOTAL MEDICAID LIAB	1,246,734.15
		LESS: COB	10,151.57
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,236,582.58

TOTAL NUMBER OF ADMISSIONS 149

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	4		218	2,719.00		148,185.50
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	4		218	2,719.00		148,185.50
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	298		0	395,098.73		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	298		0	395,098.73		0.00
TOTAL ACCOMODATIONS	302		218	397,817.73		148,185.50

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,026,508.94	0.00	OTHER LAB	43,353.89	0.00
MED/SURG SUPPLY	215,510.66	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	919,035.23	0.00	EDUCATION & TRAINING	3,244.78	0.00
RADIOLOGY-DIAGNOSTIC	179,033.77	17,884.44	OTHER THERAPEUTIC SVC	0.00	41,214.46
CT SCAN	690,037.51	6,054.46	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	70,807.70	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	53,508.69	0.00	MRI SERVICES	87,148.66	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	773,750.92	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	603,607.32	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	194,349.77	0.00	AMBULANCE	0.00	0.00
GI SERVICES	69,253.77	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	443,720.49	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	49,110.39	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,275.51	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	21,565.11	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	112.86	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	152,120.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	63,918.48	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	17,639.80	8,160.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	103,104.76	9,438.70			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	89,219.27	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	333.90	0.00			
			TOTAL ANCILLARY	5,878,272.93	82,752.06
			TOTAL ACCOMODATIONS	397,817.73	148,185.50
			TOTAL CHARGES	6,276,090.66	230,937.56

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

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

PROVIDER NUMBER
000002098A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/16	THROUGH	12/31/16
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: 08/24/2017
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NGMC BARROW, LLC
316 N BROAD ST
WINDER,GA 30680-2150

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,982,263.78	ADJUSTMENTS	365,648.69
COVERED CHARGES	11,005,471.06	CONTRACTUAL ALLOW	10,149,166.01
NON-COVERD CHARGES	976,792.72	TOTAL MEDICAID LIAB	856,305.05
		LESS: COB	3,852.98
		LESS: COPAYMENT	1,971.43
		REIMBURSEMENT	850,480.64
		ALL OTHER	770,691.08
		FEE SCHEDULE-LAB	71,002.38
		INJECTABLE DRUGS	8,787.18
		TOTAL NUMBER OF CLAIMS	2,612

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

PROVIDER NUMBER
 000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	113,160.29	58,556.12	OTHER LAB	37,633.80	0.00
MED/SURG SUPPLY	54,992.69	21.98	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	1,301.37
RADIOLOGY-DIAGNOSTIC	759,891.15	2,235.15	OTHER THERAPEUTIC SVC	0.00	7,771.51
CT SCAN	1,987,404.53	450,645.66	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	106,301.00	7,421.11	FEE SCHEDULE LAB	1,331,490.02	67,753.46
EKG/ECG	119,198.22	2,610.18	MRI SERVICES	273,782.17	34,507.05
IV THERAPY	28,177.97	1,935.13	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	601,655.13	42,463.13	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	88,423.78	38,093.26	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	373,562.97	5,120.98	AMBULANCE	0.00	0.00
GI SERVICES	273,992.48	36,915.12	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,757,340.93	18,710.72	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	166,492.95	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	325,222.14	62,800.44
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	3,537.73	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	4,596.45	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	31,209.04	29,321.54
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	168,898.32	30,020.57			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	133,272.71	46,811.64			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	39,224.28	20,836.98			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	234,144.49	2,805.44			
			TOTAL ANCILLARY	11,005,471.06	976,792.72
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,005,471.06	976,792.72

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

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

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	123,272.86	ADJUSTMENTS	0.00
COVERED CHARGES	90,369.04	CONTRACTUAL ALLOW	72,594.51
NON-COVERD CHARGES	32,903.82	TOTAL MEDICAID LIAB	17,774.53
		LESS: COB	17,744.53
		LESS: COPAYMENT	30.00
		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

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

PROVIDER NUMBER
 000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	1,160.65	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	84.76	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,007.13	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,017.92	29,636.56	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,303.00	592.00	FEE SCHEDULE LAB	10,112.62	218.60
EKG/ECG	870.06	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	389.76	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	57,349.97	211.83	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	2,446.32	96.98
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	987.20	987.20			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	800.30	0.00			
			TOTAL ANCILLARY	90,369.04	32,903.82
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	90,369.04	32,903.82

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

Run Date: 08/24/2017
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NGMC BARROW, LLC
316 N BROAD ST
WINDER,GA 30680-2150

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	720,402.06	ADJUSTMENTS	1,131.67
COVERED CHARGES	684,252.96	CONTRACTUAL ALLOW	671,330.82
NON-COVERD CHARGES	36,149.10	TOTAL MEDICAID LIAB	12,922.14
		LESS: COB	0.00
		LESS: COPAYMENT	332.50
		REIMBURSEMENT	12,589.64
		TOTAL NUMBER OF CLAIMS	231

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
 000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,446.74	3,842.25	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	716.36	3.38	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	38,573.67	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	102,497.65	23,169.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	66,381.58	2,888.97
EKG/ECG	2,175.15	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,255.68	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	2,756.24	1,483.63	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	442,393.74	806.74	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18,152.38	875.92
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,903.77	3,078.61			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	684,252.96	36,149.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	684,252.96	36,149.10

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

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

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,908.45	ADJUSTMENTS	0.00
COVERED CHARGES	8,412.25	CONTRACTUAL ALLOW	6,896.78
NON-COVERD CHARGES	496.20	TOTAL MEDICAID LIAB	1,515.47
		LESS: COB	1,515.47
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
 000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	496.20	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	92.58	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,319.67	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	8,412.25	496.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,412.25	496.20

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

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

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	557,934.19	ADJUSTMENTS	21,744.40
COVERED CHARGES	492,206.15	CONTRACTUAL ALLOW	465,003.15
NON-COVERD CHARGES	65,728.04	TOTAL MEDICAID LIAB	27,203.00
		LESS: COB	0.00
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	27,185.00

TOTAL NUMBER OF CLAIMS 5

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

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

PROVIDER NUMBER
 000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,618.19	586.36	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,420.35	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,396.49	465.79	OTHER THERAPEUTIC SVC	0.00	106.06
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	953.96	FEE SCHEDULE LAB	3,458.35	131.16
EKG/ECG	0.00	435.03	MRI SERVICES	0.00	0.00
IV THERAPY	110.35	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	377,021.76	23,516.62	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	88.49	110.93	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	59,265.45	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,929.06	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,054.89	893.66
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	71.59	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	19,914.06	34,764.57
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	3,692.31			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,928.71	0.00			
			TOTAL ANCILLARY	492,206.15	65,728.04
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	492,206.15	65,728.04

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

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

PROVIDER NUMBER
000002098A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/16	THROUGH	12/31/16
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

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 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	60,613.26	ADJUSTMENTS	4,475.91
COVERED CHARGES	60,603.26	CONTRACTUAL ALLOW	29,546.79
NON-COVERD CHARGES	10.00	TOTAL MEDICAID LIAB	31,056.47
		LESS: COB	867.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	30,189.27

TOTAL NUMBER OF ADMISSIONS 7

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	27		0	14,310.00		10.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	27		0	14,310.00		10.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	27		0	14,310.00		10.00

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 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,024.66	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,730.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,869.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,177.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	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	227.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	270.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,765.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,230.35	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.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	46,293.26	0.00
			TOTAL ACCOMODATIONS	14,310.00	10.00
			TOTAL CHARGES	60,603.26	10.00

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

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

Run Date: 08/24/2017
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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	08/01/15	THROUGH	07/31/16
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: 08/24/2017
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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 08/01/15 THROUGH 07/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,385,493.20	ADJUSTMENTS	18,886.04
COVERED CHARGES	1,284,342.34	CONTRACTUAL ALLOW	902,351.50
NON-COVERD CHARGES	101,150.86	TOTAL MEDICAID LIAB	381,990.84
		LESS: COB	583.25
		LESS: COPAYMENT	291.00
		REIMBURSEMENT	381,116.59
		ALL OTHER	346,158.66
		FEE SCHEDULE-LAB	32,069.33
		INJECTABLE DRUGS	2,888.60
		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: 08/24/2017
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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 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,533.39	2,534.21	OTHER LAB	2,295.00	0.00
MED/SURG SUPPLY	30,166.41	4,916.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	79,119.00	600.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	188,643.00	33,396.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	194.00	0.00	FEE SCHEDULE LAB	334,837.25	23,541.00
EKG/ECG	20,423.00	1,816.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,600.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,089.00	7,174.00	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	511,046.00	2,345.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	54,206.77	20,938.85
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	141.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5.40	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,053.00	2,394.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,114.00	1,086.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,324.12	268.00			
			TOTAL ANCILLARY	1,284,342.34	101,150.86
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,284,342.34	101,150.86

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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Run Time: 03:17:57
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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 08/01/15 THROUGH 07/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,862.34	ADJUSTMENTS	0.00
COVERED CHARGES	6,769.34	CONTRACTUAL ALLOW	2,830.02
NON-COVERD CHARGES	93.00	TOTAL MEDICAID LIAB	3,939.32
		LESS: COB	3,939.32
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 8

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 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	98.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	182.24	27.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	383.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,542.00	66.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	58.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,100.00	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	405.40	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,769.34	93.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,769.34	93.00

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: 08/24/2017
Run Time: 03:17:58
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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 08/01/15 THROUGH 07/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	82,705.25	ADJUSTMENTS	94.00
COVERED CHARGES	78,803.50	CONTRACTUAL ALLOW	72,503.50
NON-COVERD CHARGES	3,901.75	TOTAL MEDICAID LIAB	6,300.00
		LESS: COB	0.00
		LESS: COPAYMENT	225.00
		REIMBURSEMENT	6,075.00
		TOTAL NUMBER OF CLAIMS	126

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 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,638.23	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,311.35	63.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,367.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,302.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,827.00	1,171.00
EKG/ECG	1,135.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	214.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	58,438.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,152.92	1,821.75
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	632.00	632.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	78,803.50	3,901.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	78,803.50	3,901.75

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: 08/24/2017
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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 08/01/15 THROUGH 07/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,769.24	ADJUSTMENTS	0.00
COVERED CHARGES	1,727.24	CONTRACTUAL ALLOW	666.82
NON-COVERD CHARGES	42.00	TOTAL MEDICAID LIAB	1,060.42
		LESS: COB	1,060.42
		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: 08/24/2017
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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 08/01/15 THROUGH 07/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	115.31	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	33.93	9.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	523.00	33.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,008.00	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	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	1,727.24	42.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,727.24	42.00

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

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

Run Date: 08/24/2017
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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	08/01/15	THROUGH	07/31/16
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: 08/24/2017
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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	08/01/15	THROUGH	07/31/16
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: 08/24/2017
 Run Time: 02:26:55
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,878,455.94	ADJUSTMENTS	189,526.88
COVERED CHARGES	7,816,201.52	CONTRACTUAL ALLOW	6,054,982.59
NON-COVERD CHARGES	62,254.42	TOTAL MEDICAID LIAB	1,761,218.93
		LESS: COB	18,760.73
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,742,458.20

TOTAL NUMBER OF ADMISSIONS 250

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	256		0	160,406.84		11,242.74
ROUTINE NURSERY	72		0	24,045.72		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	328		0	184,452.56		11,242.74
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	469		0	574,102.52		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	469		0	574,102.52		0.00
TOTAL ACCOMODATIONS	797		0	758,555.08		11,242.74

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,077,514.32	0.00	OTHER LAB	99,556.45	0.00
MED/SURG SUPPLY	112,067.56	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,256,702.72	0.00	EDUCATION & TRAINING	4,282.04	0.00
RADIOLOGY-DIAGNOSTIC	222,355.36	0.00	OTHER THERAPEUTIC SVC	0.00	7,469.09
CT SCAN	731,076.77	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	62,974.68	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	123,392.87	0.00	MRI SERVICES	106,241.68	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	509,465.07	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	43,636.78	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	541,857.54	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	353,410.21	0.00	AMBULANCE	0.00	0.00
GI SERVICES	78,727.70	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	706,833.08	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	163,563.01	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	5,468.71	0.00	INJECTABLE DRUGS	5,958.07	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	34,488.51	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,761.36	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	41,829.66	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,503.12	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	110,964.37	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	5,243.37
OTHER IMAGING SERVICE	90,473.82	0.00			
BLOOD	4,996.47	0.00			
BLOOD STORAGE & PRO.	38,087.63	33,221.04			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	38,200.64	5,078.18			
AUDIOLOGY	5,357.22	0.00			
CARDIOLOGY	477,488.39	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,148.30	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	262.33	0.00			
			TOTAL ANCILLARY	7,057,646.44	51,011.68
			TOTAL ACCOMODATIONS	758,555.08	11,242.74
			TOTAL CHARGES	7,816,201.52	62,254.42

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

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

Run Date: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5916089000749	11/21/15 - 11/23/15	04/04/16	0.00	5,243.37	0.00	0.00	0.00
TOTAL				0.00	5,243.37	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: 08/24/2017
 Run Time: 02:27:02
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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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	60,290.49	ADJUSTMENTS	0.00
COVERED CHARGES	60,290.49	CONTRACTUAL ALLOW	45,984.47
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	14,306.02
		LESS: COB	14,306.02
		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	10		0	5,897.80		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	10		0	5,897.80		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	5,897.80		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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,086.91	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,023.46	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,936.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	13,941.10	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,510.75	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,980.72	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	510.10	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,509.14	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	293.97	0.00	INJECTABLE DRUGS	9,600.54	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	54,392.69	0.00
			TOTAL ACCOMODATIONS	5,897.80	0.00
			TOTAL CHARGES	60,290.49	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: 08/24/2017
Run Time: 02:27:03
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,114,450.34	ADJUSTMENTS	509,612.29
COVERED CHARGES	16,352,315.26	CONTRACTUAL ALLOW	14,828,207.76
NON-COVERD CHARGES	1,762,135.08	TOTAL MEDICAID LIAB	1,524,107.50
		LESS: COB	3,676.40
		LESS: COPAYMENT	2,669.74
		REIMBURSEMENT	1,517,761.36
		ALL OTHER	1,379,204.77
		FEE SCHEDULE-LAB	109,068.58
		INJECTABLE DRUGS	29,488.01

TOTAL NUMBER OF CLAIMS 4,185

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	127,672.46	194,062.20	OTHER LAB	210,622.43	0.00
MED/SURG SUPPLY	177,995.87	12,575.94	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	1,777.86
RADIOLOGY-DIAGNOSTIC	774,932.54	13,655.72	OTHER THERAPEUTIC SVC	0.00	100,499.36
CT SCAN	2,325,607.03	621,624.28	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	23,747.00	1,736.27	FEE SCHEDULE LAB	1,876,114.79	84,403.50
EKG/ECG	317,556.07	8,417.24	MRI SERVICES	264,332.24	20,764.82
IV THERAPY	16,841.40	7,191.67	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	729,686.16	204,962.05	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	109,417.70	28,886.46	FREE STANDING CLINIC	3,296.79	242.28
ANESTHESIA	578,278.55	0.00	AMBULANCE	0.00	0.00
GI SERVICES	228,813.76	7,798.54	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,497,814.48	102,785.47	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	398,997.08	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	421,945.73	56,391.22
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	510.43	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,682.11	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	6,247.85	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	13,774.74	34,515.87
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	427,378.01	71,892.10			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,075.65	2,992.86			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	143,275.81	59,122.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	204,711.33	64,170.01			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	476,427.64	51,226.47			
			TOTAL ANCILLARY	16,352,315.26	1,762,135.08
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,352,315.26	1,762,135.08

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

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	332,204.38	ADJUSTMENTS	0.00
COVERED CHARGES	263,705.90	CONTRACTUAL ALLOW	185,044.66
NON-COVERD CHARGES	68,498.48	TOTAL MEDICAID LIAB	78,661.24
		LESS: COB	78,634.30
		LESS: COPAYMENT	26.94
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	70

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	227.68	4,415.30	OTHER LAB	3,127.15	0.00
MED/SURG SUPPLY	5,666.05	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,274.54	705.50	OTHER THERAPEUTIC SVC	0.00	425.51
CT SCAN	10,433.18	15,651.82	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	27,309.32	3,232.18
EKG/ECG	5,377.11	0.00	MRI SERVICES	5,748.21	10,626.28
IV THERAPY	1,249.22	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	26,811.20	9,184.03	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	534.33	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	31,593.38	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,354.23	7,511.10	CAST ROOM	0.00	0.00
EMERGENCY ROOM	89,825.17	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,991.88	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,811.31	4,796.02
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	130.35	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,643.21	9,184.39			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,728.73	2,636.00			
			TOTAL ANCILLARY	263,705.90	68,498.48
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	263,705.90	68,498.48

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: 08/24/2017
Run Time: 02:28:00
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	955,233.43	ADJUSTMENTS	2,053.26
COVERED CHARGES	899,917.50	CONTRACTUAL ALLOW	878,660.30
NON-COVERD CHARGES	55,315.93	TOTAL MEDICAID LIAB	21,257.20
		LESS: COB	2.86
		LESS: COPAYMENT	571.66
		REIMBURSEMENT	20,682.68
		TOTAL NUMBER OF CLAIMS	380

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,231.10	9,059.87	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,285.24	512.58	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	66.85
RADIOLOGY-DIAGNOSTIC	29,576.89	0.00	OTHER THERAPEUTIC SVC	0.00	2,467.74
CT SCAN	141,679.17	24,129.24	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	85,969.87	2,892.52
EKG/ECG	6,528.85	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,546.97	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,953.80	356.22	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,576.29	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	542,411.68	3,632.02	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,603.83	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	27,198.98	1,620.24
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	373.52	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	22,370.52	10,205.13			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,984.31	0.00			
			TOTAL ANCILLARY	899,917.50	55,315.93
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	899,917.50	55,315.93

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

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

Run Date: 08/24/2017
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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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,484.44	ADJUSTMENTS	0.00
COVERED CHARGES	19,365.26	CONTRACTUAL ALLOW	14,646.94
NON-COVERD CHARGES	8,119.18	TOTAL MEDICAID LIAB	4,718.32
		LESS: COB	4,703.32
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	55.60	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	1,107.57	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	7,023.07	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,093.70	156.26
EKG/ECG	526.58	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,461.98	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	23.02	9.73
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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,152.41	874.52			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	19,365.26	8,119.18
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	19,365.26	8,119.18

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 10/01/15 THROUGH 09/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	540,214.20	ADJUSTMENTS	38,060.99
COVERED CHARGES	530,189.59	CONTRACTUAL ALLOW	492,105.39
NON-COVERD CHARGES	10,024.61	TOTAL MEDICAID LIAB	38,084.20
		LESS: COB	0.00
		LESS: COPAYMENT	23.21
		REIMBURSEMENT	38,060.99

TOTAL NUMBER OF CLAIMS 7

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 10/01/15 THROUGH 09/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,121.03	439.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	12,466.26	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,903.88	0.00	OTHER THERAPEUTIC SVC	0.00	2,990.29
CT SCAN	20,039.90	3,732.34	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,828.75	206.99
EKG/ECG	1,808.48	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	188,469.39	3.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	68,342.38	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,724.17	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,220.66	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	89,876.53	1,984.53
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,133.79	0.00
LITHOTRIPSY	100,401.74	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,852.63	668.46			
			TOTAL ANCILLARY	530,189.59	10,024.61
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	530,189.59	10,024.61

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: 08/24/2017
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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	10/01/15	THROUGH	09/30/16
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: 08/24/2017
 Run Time: 02:17:14
 Page: 1

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,002,574.35	ADJUSTMENTS	206,261.80
COVERED CHARGES	1,971,137.35	CONTRACTUAL ALLOW	1,406,043.98
NON-COVERD CHARGES	31,437.00	TOTAL MEDICAID LIAB	565,093.37
		LESS: COB	16,532.96
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	548,560.41

TOTAL NUMBER OF ADMISSIONS 79

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	259		0	172,235.00		28,777.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		2,660.00
TOTAL ROUTINE	259		0	172,235.00		31,437.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	97		0	117,300.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	97		0	117,300.00		0.00
TOTAL ACCOMODATIONS	356		0	289,535.00		31,437.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	381,753.00	0.00	OTHER LAB	4,842.00	0.00
MED/SURG SUPPLY	94,403.24	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	318,259.00	0.00	EDUCATION & TRAINING	900.00	0.00
RADIOLOGY-DIAGNOSTIC	36,174.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	88,310.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	16,069.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	16,068.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,247.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	49,390.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	156,029.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	28,365.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	112,938.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,719.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,531.16	0.00	INJECTABLE DRUGS	205,779.86	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	90.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	124,843.09	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,848.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,452.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	21,354.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,238.00	0.00			
			TOTAL ANCILLARY	1,681,602.35	0.00
			TOTAL ACCOMODATIONS	289,535.00	31,437.00
			TOTAL CHARGES	1,971,137.35	31,437.00

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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,754,872.67	ADJUSTMENTS	28,552.53
COVERED CHARGES	1,668,933.69	CONTRACTUAL ALLOW	1,361,889.89
NON-COVERD CHARGES	85,938.98	TOTAL MEDICAID LIAB	307,043.80
		LESS: COB	1,492.42
		LESS: COPAYMENT	1,587.00
		REIMBURSEMENT	303,964.38
		ALL OTHER	274,695.11
		FEE SCHEDULE-LAB	26,552.32
		INJECTABLE DRUGS	2,716.95

TOTAL NUMBER OF CLAIMS 892

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	90,819.00	1,135.00	OTHER LAB	3,431.00	0.00
MED/SURG SUPPLY	86,279.43	184.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	310.00
RADIOLOGY-DIAGNOSTIC	82,496.00	977.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	248,061.00	12,713.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	323,744.76	16,159.00
EKG/ECG	11,948.00	1,236.00	MRI SERVICES	0.00	0.00
IV THERAPY	19,113.00	1,797.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	89,626.00	4,866.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,953.00	7,215.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	74,300.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	362,714.00	490.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,539.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	66,100.00	19,656.98
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	9,451.00	980.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	109,583.00	6,933.00	IMPL DEV CHARGE PATIENTS	6,130.50	1,071.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	32,492.00	1,320.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,010.00	2,365.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,721.00	733.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	5,625.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,556.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	20,866.00	173.00			
			TOTAL ANCILLARY	1,668,933.69	85,938.98
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,668,933.69	85,938.98

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

Run Date: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	34,780.00	ADJUSTMENTS	0.00
COVERED CHARGES	25,201.00	CONTRACTUAL ALLOW	14,469.47
NON-COVERD CHARGES	9,579.00	TOTAL MEDICAID LIAB	10,731.53
		LESS: COB	10,698.53
		LESS: COPAYMENT	33.00
		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

CHESTATEE REGIONAL HOSPITAL
 227 MOUNTAIN DR
 DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
 000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,707.00	1,300.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,509.00	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	2,157.00	5,451.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,913.00	350.00
EKG/ECG	412.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,148.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	683.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,247.00	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	938.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	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	2,690.00	2,346.00	IMPL 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	260.00	0.00			
			TOTAL ANCILLARY	25,201.00	9,579.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,201.00	9,579.00

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	38,015.96	ADJUSTMENTS	0.00
COVERED CHARGES	37,518.96	CONTRACTUAL ALLOW	33,686.04
NON-COVERD CHARGES	497.00	TOTAL MEDICAID LIAB	3,832.92
		LESS: COB	37.37
		LESS: COPAYMENT	135.57
		REIMBURSEMENT	3,659.98
		TOTAL NUMBER OF CLAIMS	69

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	715.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	339.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,589.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,345.00	288.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	94.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	26,819.00	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	2,119.96	99.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	498.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	37,518.96	497.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	37,518.96	497.00

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: 08/24/2017
Run Time: 02:17:35
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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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
Run Time: 02:17:36
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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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
Run Time: 02:17:36
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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	07/01/15	THROUGH	06/30/16
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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,390,693.13	ADJUSTMENTS	134,838.18
COVERED CHARGES	4,326,116.36	CONTRACTUAL ALLOW	3,580,617.01
NON-COVERD CHARGES	64,576.77	TOTAL MEDICAID LIAB	745,499.35
		LESS: COB	4,843.23
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	740,656.12

TOTAL NUMBER OF ADMISSIONS 173

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	154		47	153,561.00		54,556.41
ROUTINE NURSERY	129		0	94,728.38		2,157.53
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	283		47	248,289.38		56,713.94
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	71		0	107,110.43		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	71		0	107,110.43		0.00
TOTAL ACCOMODATIONS	354		47	355,399.81		56,713.94

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

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	386,941.75	0.00	OTHER LAB	2,700.78	0.00
MED/SURG SUPPLY	85,492.96	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	829,356.82	0.00	EDUCATION & TRAINING	3,407.00	0.00
RADIOLOGY-DIAGNOSTIC	34,114.98	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	113,628.84	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,861.27	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	32,320.68	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	536,363.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	572,614.17	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	92,607.60	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	121,268.90	0.00	AMBULANCE	0.00	0.00
GI SERVICES	7,613.68	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	140,687.34	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	35,422.92	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	17,839.32	0.00	INJECTABLE DRUGS	848,022.80	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,264.04	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	448.83	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,242.03	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	25,733.29	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,677.61	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,445.12	7,343.03			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,668.67	519.80			
AUDIOLOGY	13,180.27	0.00			
CARDIOLOGY	15,773.80	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	8,017.83	0.00			
			TOTAL ANCILLARY	3,970,716.55	7,862.83
			TOTAL ACCOMODATIONS	355,399.81	56,713.94
			TOTAL CHARGES	4,326,116.36	64,576.77

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,372.64	ADJUSTMENTS	0.00
COVERED CHARGES	29,110.41	CONTRACTUAL ALLOW	25,611.21
NON-COVERD CHARGES	262.23	TOTAL MEDICAID LIAB	3,499.20
		LESS: COB	3,499.20
		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	3		0	2,844.00		262.23
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3		0	2,844.00		262.23
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	3		0	2,844.00		262.23

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

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

Run Date: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,059.81	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	849.18	0.00	EDUCATION & TRAINING	170.35	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	16,699.62	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,500.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,987.45	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	26,266.41	0.00
			TOTAL ACCOMODATIONS	2,844.00	262.23
			TOTAL CHARGES	29,110.41	262.23

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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,273,395.53	ADJUSTMENTS	246,795.29
COVERED CHARGES	5,808,742.25	CONTRACTUAL ALLOW	5,241,129.73
NON-COVERD CHARGES	464,653.28	TOTAL MEDICAID LIAB	567,612.52
		LESS: COB	3,008.29
		LESS: COPAYMENT	1,089.00
		REIMBURSEMENT	563,515.23
		ALL OTHER	493,867.90
		FEE SCHEDULE-LAB	58,918.84
		INJECTABLE DRUGS	10,728.49
		TOTAL NUMBER OF CLAIMS	1,307

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	273,217.42	15,714.45	OTHER LAB	86,968.10	0.00
MED/SURG SUPPLY	28,229.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	301.45	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	161,936.28	617.35	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	443,694.23	68,803.47	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	29,002.25	4,634.45	FEE SCHEDULE LAB	1,742,787.50	57,836.77
EKG/ECG	85,418.94	2,693.39	MRI SERVICES	91,661.03	0.00
IV THERAPY	23,885.34	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	595,242.10	96,736.01	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,281.44	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	32,518.77	1,967.04	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	179,256.27	0.00	AMBULANCE	0.00	0.00
GI SERVICES	152,552.46	13,280.09	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,097,717.56	9,624.71	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	125,279.48	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	358,906.23	130,968.62
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	9,681.84	10,133.25	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,653.91	1,919.28	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	24,669.07
LITHOTRIPSY	85,978.28	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	59,065.35	8,093.97			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	12,294.48	2,234.09			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	38,048.47	3,874.22			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	25,718.00	2,027.20			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	62,746.77	8,524.40			
			TOTAL ANCILLARY	5,808,742.25	464,653.28
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,808,742.25	464,653.28

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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,212.58	ADJUSTMENTS	0.00
COVERED CHARGES	11,518.96	CONTRACTUAL ALLOW	7,774.67
NON-COVERD CHARGES	1,693.62	TOTAL MEDICAID LIAB	3,744.29
		LESS: COB	3,741.29
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 7

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	422.28	410.81	OTHER LAB	3,491.10	0.00
MED/SURG SUPPLY	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	1,919.79	43.90
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	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,070.36	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,168.71	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	446.72	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,238.91			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	11,518.96	1,693.62
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,518.96	1,693.62

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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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	117,809.90	ADJUSTMENTS	55.94
COVERED CHARGES	112,634.62	CONTRACTUAL ALLOW	109,054.46
NON-COVERD CHARGES	5,175.28	TOTAL MEDICAID LIAB	3,580.16
		LESS: COB	0.00
		LESS: COPAYMENT	117.00
		REIMBURSEMENT	3,463.16
		TOTAL NUMBER OF CLAIMS	64

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

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,977.38	91.93	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,069.49	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,518.72	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	29,776.72	1,170.62
EKG/ECG	1,539.08	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	265.38	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	52,200.89	745.02	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,643.96	3,167.71
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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,672.73	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	970.27	0.00			
			TOTAL ANCILLARY	112,634.62	5,175.28
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	112,634.62	5,175.28

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,130.06	ADJUSTMENTS	0.00
COVERED CHARGES	1,130.06	CONTRACTUAL ALLOW	330.06
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	800.00
		LESS: COB	800.00
		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

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 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	412.64	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	717.42	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,130.06	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,130.06	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

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,392,497.72	ADJUSTMENTS	81,972.90
COVERED CHARGES	1,308,068.21	CONTRACTUAL ALLOW	1,193,255.75
NON-COVERD CHARGES	84,429.51	TOTAL MEDICAID LIAB	114,812.46
		LESS: COB	0.00
		LESS: COPAYMENT	53.17
		REIMBURSEMENT	114,759.29
		TOTAL NUMBER OF CLAIMS	21

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35,583.35	6,419.19	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	16,598.69	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,189.73	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,506.24	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	22,765.63	263.40
EKG/ECG	1,154.31	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	943,884.87	20,779.54	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	438.24	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	175,266.15	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,128.20	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	54,908.91	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	40,178.53	16,859.53
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	35,701.35
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,238.91	900.26			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,732.69	0.00			
			TOTAL ANCILLARY	1,308,068.21	84,429.51
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,308,068.21	84,429.51

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: 08/24/2017
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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	01/01/16	THROUGH	12/31/16
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	07/01/15	THROUGH	06/30/16
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

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

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

Run Date: 08/24/2017
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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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
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

Run Date: 08/24/2017
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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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
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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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
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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	07/01/15	THROUGH	06/30/16
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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
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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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
 Run Time: 02:58:58
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,373,557.57	ADJUSTMENTS	30,397.05
COVERED CHARGES	10,411,957.57	CONTRACTUAL ALLOW	5,641,328.29
NON-COVERD CHARGES	961,600.00	TOTAL MEDICAID LIAB	4,770,629.28
		LESS: COB	11,472.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,759,157.08

TOTAL NUMBER OF ADMISSIONS 1,164

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5,194		0	3,148,600.00		961,600.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5,194		0	3,148,600.00		961,600.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	5,194		0	3,148,600.00		961,600.00

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,914,451.94	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	596,029.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	57,854.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,476.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	674.31	0.00	MRI SERVICES	15,468.00	0.00
IV THERAPY	308.36	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	4,663,579.96	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	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	7,263,357.57	0.00
			TOTAL ACCOMODATIONS	3,148,600.00	961,600.00
			TOTAL CHARGES	10,411,957.57	961,600.00

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 01/01/16 THROUGH 12/31/16
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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PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	132,212.04	ADJUSTMENTS	841.65
COVERED CHARGES	129,446.08	CONTRACTUAL ALLOW	72,154.69
NON-COVERD CHARGES	2,765.96	TOTAL MEDICAID LIAB	57,291.39
		LESS: COB	57.52
		LESS: COPAYMENT	273.00
		REIMBURSEMENT	56,960.87
		ALL OTHER	54,926.74
		FEE SCHEDULE-LAB	2,034.13
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 180

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

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

Run Date: 08/24/2017
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SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

PREMIER HEALTHCARE INVESTMENTS
 509 SUMTER STREET
 MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
 000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 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	39,057.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	60,988.00	936.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,986.54	1,313.96
EKG/ECG	449.54	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	10,965.00	516.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	129,446.08	2,765.96
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	129,446.08	2,765.96

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

PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/16	THROUGH	12/31/16
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: 08/24/2017
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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	01/01/16	THROUGH	12/31/16
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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PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/16	THROUGH	12/31/16
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: 08/24/2017
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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	01/01/16	THROUGH	12/31/16
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: 08/24/2017
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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	01/01/16	THROUGH	12/31/16
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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	31,637,247.79	ADJUSTMENTS	2,145,077.56
COVERED CHARGES	30,947,537.44	CONTRACTUAL ALLOW	23,598,201.04
NON-COVERD CHARGES	689,710.35	TOTAL MEDICAID LIAB	7,349,336.40
		LESS: COB	59,486.07
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,289,850.33

TOTAL NUMBER OF ADMISSIONS 718

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,079		3	2,563,776.00		432,586.00
ROUTINE NURSERY	339		0	570,829.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,418		3	3,134,605.00		432,586.00
SPECIAL CARE SERVICES						
CCU	577		0	1,551,469.00		0.00
ICU	360		0	955,800.00		0.00
NICU	194		0	606,815.00		40,551.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,131		0	3,114,084.00		40,551.00
TOTAL ACCOMODATIONS	4,549		3	6,248,689.00		473,137.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,088,581.08	665.40	OTHER LAB	250,061.00	0.00
MED/SURG SUPPLY	644,788.71	14,245.95	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,908,935.00	18,036.00	EDUCATION & TRAINING	5,910.00	0.00
RADIOLOGY-DIAGNOSTIC	555,888.00	519.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,127,861.00	6,710.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	155,840.97	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	180,153.00	0.00	MRI SERVICES	317,039.00	0.00
IV THERAPY	1,395.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,480,869.00	8,121.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	250,141.00	2,998.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,611,202.00	17,448.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	255,154.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	230,071.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,916,265.00	5,731.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	317,171.00	1,654.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	164,822.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	8,863.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	81,211.29	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	76,253.05	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	546,915.00	26,866.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	13,368.00	813.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	749,520.54	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	212,395.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	457,889.00	72,104.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	188,034.00	37,364.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	821,114.00	3,297.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	45,613.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	35,524.80	0.00			
			TOTAL ANCILLARY	24,698,848.44	216,573.35
			TOTAL ACCOMODATIONS	6,248,689.00	473,137.00
			TOTAL CHARGES	30,947,537.44	689,710.35

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	350,759.89	ADJUSTMENTS	0.00
COVERED CHARGES	335,230.89	CONTRACTUAL ALLOW	188,591.44
NON-COVERD CHARGES	15,529.00	TOTAL MEDICAID LIAB	146,639.45
		LESS: COB	146,639.45
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 23

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	52		0	43,316.00		15,529.00
ROUTINE NURSERY	12		0	4,380.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	64		0	47,696.00		15,529.00
SPECIAL CARE SERVICES						
CCU	2		0	5,380.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	5,380.00		0.00
TOTAL ACCOMODATIONS	66		0	53,076.00		15,529.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48,090.65	0.00	OTHER LAB	1,368.00	0.00
MED/SURG SUPPLY	11,136.24	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	48,092.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,440.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,884.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	354.00	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	28,223.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	77,362.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,309.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,852.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,925.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,059.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,910.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,477.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,653.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,538.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,816.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	282,154.89	0.00
			TOTAL ACCOMODATIONS	53,076.00	15,529.00
			TOTAL CHARGES	335,230.89	15,529.00

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: 08/24/2017
Run Time: 03:19:41
Page: 5

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,937,337.17	ADJUSTMENTS	524,346.09
COVERED CHARGES	19,932,239.03	CONTRACTUAL ALLOW	16,923,886.15
NON-COVERD CHARGES	3,005,098.14	TOTAL MEDICAID LIAB	3,008,352.88
		LESS: COB	86,899.10
		LESS: COPAYMENT	4,032.90
		REIMBURSEMENT	2,917,420.88
		ALL OTHER	2,694,999.71
		FEE SCHEDULE-LAB	190,590.78
		INJECTABLE DRUGS	31,830.39

TOTAL NUMBER OF CLAIMS 5,989

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	352,734.13	9,863.35	OTHER LAB	323,133.00	119,944.00
MED/SURG SUPPLY	352,873.46	54,798.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	100.00
RADIOLOGY-DIAGNOSTIC	1,107,257.00	19,453.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,514,946.00	469,804.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,580.00	6,602.20	FEE SCHEDULE LAB	3,418,667.00	189,095.00
EKG/ECG	323,010.00	6,327.00	MRI SERVICES	208,371.00	76,334.00
IV THERAPY	2,816.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,735,033.95	394,569.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	118,653.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	65,696.00	20,408.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	261,848.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	167,200.00	34,677.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,026,974.00	89,416.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	454,491.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	536.00	INJECTABLE DRUGS	378,050.63	235,668.25
RADIOLOGY THERAPEUTIC	236,581.00	235,468.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	462.00	4,008.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	11,647.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	237,956.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	81,604.00	5,951.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	14,608.57	152,213.84
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	561,754.00	250,700.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	53,553.00	18,676.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	226,922.00	194,509.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	349,254.00	159,218.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	38,528.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	555,638.29	7,156.00			
			TOTAL ANCILLARY	19,932,239.03	3,005,098.14
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	19,932,239.03	3,005,098.14

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

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	318,390.06	ADJUSTMENTS	0.00
COVERED CHARGES	251,269.23	CONTRACTUAL ALLOW	165,859.54
NON-COVERD CHARGES	67,120.83	TOTAL MEDICAID LIAB	85,409.69
		LESS: COB	85,397.45
		LESS: COPAYMENT	12.24
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 79

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,920.95	0.00	OTHER LAB	584.00	1,492.00
MED/SURG SUPPLY	3,475.51	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,421.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,527.00	17,976.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	50,380.00	4,648.00
EKG/ECG	3,663.00	333.00	MRI SERVICES	2,900.00	6,886.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	24,835.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,270.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	334.00	220.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,143.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	98,462.00	528.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,578.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,154.97	1,921.83
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,396.00	8,036.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	20,466.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,511.00	4,614.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,713.80	0.00			
			TOTAL ANCILLARY	251,269.23	67,120.83
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	251,269.23	67,120.83

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: 08/24/2017
Run Time: 03:20:32
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,340,740.32	ADJUSTMENTS	1,501.90
COVERED CHARGES	1,192,829.84	CONTRACTUAL ALLOW	1,154,961.43
NON-COVERD CHARGES	147,910.48	TOTAL MEDICAID LIAB	37,868.41
		LESS: COB	1,451.47
		LESS: COPAYMENT	1,126.91
		REIMBURSEMENT	35,290.03
		TOTAL NUMBER OF CLAIMS	651

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,221.71	332.80	OTHER LAB	13,338.00	7,460.00
MED/SURG SUPPLY	5,198.59	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	59,511.00	540.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	62,146.00	24,216.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	231,783.00	8,346.00
EKG/ECG	14,319.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	373.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	734,985.00	1,692.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,936.54	6,597.68
RADIOLOGY THERAPEUTIC	11,682.00	81,144.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	31,507.00	17,433.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,557.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,272.00	149.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,192,829.84	147,910.48
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,192,829.84	147,910.48

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: 08/24/2017
Run Time: 03:20:38
Page: 11

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	28,977.86	ADJUSTMENTS	0.00
COVERED CHARGES	27,205.86	CONTRACTUAL ALLOW	17,741.53
NON-COVERD CHARGES	1,772.00	TOTAL MEDICAID LIAB	9,464.33
		LESS: COB	9,452.33
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	15

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	249.86	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	97.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,674.00	478.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,335.00	224.00
EKG/ECG	333.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	167.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,350.00	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,070.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	27,205.86	1,772.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	27,205.86	1,772.00

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

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

Run Date: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,390,758.95	ADJUSTMENTS	55,047.25
COVERED CHARGES	1,120,470.82	CONTRACTUAL ALLOW	971,125.04
NON-COVERD CHARGES	270,288.13	TOTAL MEDICAID LIAB	149,345.78
		LESS: COB	8,171.03
		LESS: COPAYMENT	84.00
		REIMBURSEMENT	141,090.75

TOTAL NUMBER OF CLAIMS 27

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,416.22	249.60	OTHER LAB	4,476.00	1,492.00
MED/SURG SUPPLY	90,612.23	6,911.22	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,523.00	449.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,816.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	33,541.00	1,568.00
EKG/ECG	0.00	333.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	563,291.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,122.00	128.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	50,266.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,902.00	1,322.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	66,826.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,470.87	8,202.04
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	19,513.21	245,691.27
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,236.00	3,513.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	429.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	201,445.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	16,014.29	0.00			
			TOTAL ANCILLARY	1,120,470.82	270,288.13
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,120,470.82	270,288.13

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: 08/24/2017
Run Time: 03:20:41
Page: 15

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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
 Run Time: 02:51:40
 Page: 1

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	65,182,662.34	ADJUSTMENTS	2,053,463.33
COVERED CHARGES	55,499,405.41	CONTRACTUAL ALLOW	46,767,168.77
NON-COVERD CHARGES	9,683,256.93	TOTAL MEDICAID LIAB	8,732,236.64
		LESS: COB	114,726.94
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,617,509.70

TOTAL NUMBER OF ADMISSIONS 1,146

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7,166		0	9,454,400.20		8,743,368.88
ROUTINE NURSERY	497		0	759,895.00		124,743.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	7,663		0	10,214,295.20		8,868,111.88
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,070		0	2,930,450.00		0.00
NICU	30		0	100,950.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,100		0	3,031,400.00		0.00
TOTAL ACCOMODATIONS	8,763		0	13,245,695.20		8,868,111.88

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,274,400.17	19,121.95	OTHER LAB	306,170.31	0.00
MED/SURG SUPPLY	2,565,342.25	23,640.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,475,594.53	45,911.39	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	854,707.59	3,496.89	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,620,863.95	35,711.35	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	555,718.71	7,319.20	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	651,257.46	1,370.32	MRI SERVICES	482,268.97	4,858.01
IV THERAPY	3,911.40	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,736,210.67	17,295.23	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	275,048.34	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,287,099.47	1,943.34	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	618,039.94	0.00	AMBULANCE	0.00	0.00
GI SERVICES	509,738.40	5,248.80	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,044,922.74	4,082.92	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	504,170.64	0.00	DRUG-SPECIFIC/HOME IV	0.00	3,295.62
LABORATORY PATHOLOGIC	282,344.50	0.00	INJECTABLE DRUGS	6,751,785.26	491,986.54
RADIOLOGY THERAPEUTIC	0.00	3,371.28	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	359,834.68	5,026.79	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	268,593.10	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	285,489.10	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	23,412.71	164.76	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	202,668.95	0.00	IMPL DEV CHARGE PATIENTS	1,135,258.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	343,222.50	6,536.04			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	114,793.66	133,701.24			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	621,556.06	1,062.88			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	876,864.60	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	80,352.52	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	142,068.28	0.00			
			TOTAL ANCILLARY	42,253,710.21	815,145.05
			TOTAL ACCOMODATIONS	13,245,695.20	8,868,111.88
			TOTAL CHARGES	55,499,405.41	9,683,256.93

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

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

Run Date: 08/24/2017
 Run Time: 02:51:52
 Page: 3

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	262,497.14	ADJUSTMENTS	0.00
COVERED CHARGES	257,902.14	CONTRACTUAL ALLOW	161,597.57
NON-COVERD CHARGES	4,595.00	TOTAL MEDICAID LIAB	96,304.57
		LESS: COB	96,304.57
		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	22		0	28,529.00		4,595.00
ROUTINE NURSERY	7		0	15,225.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	29		0	43,754.00		4,595.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	29		0	43,754.00		4,595.00

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,450.75	0.00	OTHER LAB	2,204.43	0.00
MED/SURG SUPPLY	10,051.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	38,701.99	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,671.94	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,143.67	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	503.10	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	685.16	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	18,052.60	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	43,262.37	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,871.69	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,385.64	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,581.62	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	15,449.39	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,812.03	0.00	INJECTABLE DRUGS	22,411.95	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	82.38	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,468.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,040.30	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	4,317.63	0.00			
			TOTAL ANCILLARY	214,148.14	0.00
			TOTAL ACCOMODATIONS	43,754.00	4,595.00
			TOTAL CHARGES	257,902.14	4,595.00

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: 08/24/2017
Run Time: 02:51:53
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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,253,984.56	ADJUSTMENTS	136,527.87
COVERED CHARGES	16,570,896.58	CONTRACTUAL ALLOW	15,073,874.79
NON-COVERD CHARGES	1,683,087.98	TOTAL MEDICAID LIAB	1,497,021.79
		LESS: COB	1,648.22
		LESS: COPAYMENT	2,879.35
		REIMBURSEMENT	1,492,494.22
		ALL OTHER	1,380,633.17
		FEE SCHEDULE-LAB	92,803.96
		INJECTABLE DRUGS	19,057.09

TOTAL NUMBER OF CLAIMS 3,555

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	433,306.99	2,202.74	OTHER LAB	181,164.16	0.00
MED/SURG SUPPLY	389,904.50	9,029.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	787.79	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	812,029.23	15,716.58	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,102,049.74	216,146.66	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	38,668.88	20,511.63	FEE SCHEDULE LAB	3,257,336.77	394,352.47
EKG/ECG	375,721.57	1,370.32	MRI SERVICES	183,930.70	26,691.78
IV THERAPY	677,509.96	6,158.38	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	913,873.16	249,672.35	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	55,395.40	4,700.06	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	43,211.44	106,783.58	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	284,990.50	3,164.57	AMBULANCE	0.00	0.00
GI SERVICES	48,347.28	6,940.08	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,245,806.76	14,556.55	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	591,782.87	4,259.20	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	195,851.84	24,920.63
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	17,645.98	5,879.52	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,445.09	4,930.07	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	44,195.37	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	90,971.76	10,792.03	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	115,075.27	0.00	IMPL DEV CHARGE PATIENTS	217,605.00	1,479.50
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	432,590.86	163,908.81			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,559.40	11,227.26			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	450,762.02	65,268.63			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	150,853.84	116,171.71			
AMBULATORY SURGERY	165.02	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	45,110.18	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	207,230.41	151,270.21			
			TOTAL ANCILLARY	16,570,896.58	1,683,087.98
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,570,896.58	1,683,087.98

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

Run Date: 08/24/2017
Run Time: 02:52:16
Page: 7

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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	331,353.56	ADJUSTMENTS	0.00
COVERED CHARGES	268,912.99	CONTRACTUAL ALLOW	191,368.95
NON-COVERD CHARGES	62,440.57	TOTAL MEDICAID LIAB	77,544.04
		LESS: COB	77,502.04
		LESS: COPAYMENT	42.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 81

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,635.16	0.00	OTHER LAB	13,701.71	0.00
MED/SURG SUPPLY	1,503.25	3,270.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,574.00	706.66	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,991.34	6,884.52	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	62,247.22	10,895.72
EKG/ECG	4,060.21	0.00	MRI SERVICES	9,975.88	22,545.28
IV THERAPY	8,413.19	1,102.66	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,746.86	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,578.04	1,559.82	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	272.07	374.62	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	85,060.78	6,005.30	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,538.29	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	591.50	0.00
RADIOLOGY THERAPEUTIC	0.00	474.89	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	336.40	273.05	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,687.09	7,364.89			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	983.16			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	268,912.99	62,440.57
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	268,912.99	62,440.57

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: 08/24/2017
Run Time: 02:52:17
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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,272,598.94	ADJUSTMENTS	597.34
COVERED CHARGES	1,186,836.20	CONTRACTUAL ALLOW	1,164,068.62
NON-COVERD CHARGES	85,762.74	TOTAL MEDICAID LIAB	22,767.58
		LESS: COB	0.00
		LESS: COPAYMENT	638.07
		REIMBURSEMENT	22,129.51
		TOTAL NUMBER OF CLAIMS	407

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,945.04	0.00	OTHER LAB	5,234.02	0.00
MED/SURG SUPPLY	1,856.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	64,134.39	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	127,633.01	23,678.13	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	281,144.11	54,744.20
EKG/ECG	21,772.87	0.00	MRI SERVICES	5,575.61	0.00
IV THERAPY	58,980.51	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	544.05	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	644.49	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	579,252.23	2,773.49	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	4,245.06	1,561.77
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	19,874.06	3,005.15			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,186,836.20	85,762.74
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,186,836.20	85,762.74

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

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

Run Date: 08/24/2017
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Page: 11

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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,916.20	ADJUSTMENTS	0.00
COVERED CHARGES	11,916.20	CONTRACTUAL ALLOW	7,808.33
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	4,107.87
		LESS: COB	4,101.87
		LESS: COPAYMENT	6.00
		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: 08/24/2017
 Run Time: 02:52:20
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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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 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	659.30	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	4,412.74	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,807.42	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	36.74	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	11,916.20	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,916.20	0.00

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

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

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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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,122,129.96	ADJUSTMENTS	0.00
COVERED CHARGES	1,042,840.73	CONTRACTUAL ALLOW	976,091.09
NON-COVERD CHARGES	79,289.23	TOTAL MEDICAID LIAB	66,749.64
		LESS: COB	0.00
		LESS: COPAYMENT	105.00
		REIMBURSEMENT	66,644.64

TOTAL NUMBER OF CLAIMS 12

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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,153.52	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	89,763.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,675.21	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,684.62	FEE SCHEDULE LAB	25,781.49	214.72
EKG/ECG	3,425.80	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,993.02	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	232,738.98	37,374.93	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,504.16	19,444.14	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	38,612.15	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,285.90	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	52,911.83	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	38,798.66	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,887.23	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	393,650.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	112,883.16	18,683.59			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,663.10	0.00			
			TOTAL ANCILLARY	1,042,840.73	79,289.23
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,042,840.73	79,289.23

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: 08/24/2017
Run Time: 02:52:22
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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	09/01/15	THROUGH	08/31/16
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

DONALSONVILLE HOSPITAL INC
 102 HOSPITAL CIR
 DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER 000206181A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	948,909.00	ADJUSTMENTS	50,021.65
COVERED CHARGES	906,532.00	CONTRACTUAL ALLOW	529,957.41
NON-COVERD CHARGES	42,377.00	TOTAL MEDICAID LIAB	376,574.59
		LESS: COB	3,985.22
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	372,589.37

TOTAL NUMBER OF ADMISSIONS 97

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	185		6	124,875.00		41,460.00
ROUTINE NURSERY	64		0	41,858.00		587.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	249		6	166,733.00		42,047.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	249		6	166,733.00		42,047.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	318,730.00	0.00	OTHER LAB	510.00	0.00
MED/SURG SUPPLY	125,468.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	97,250.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,632.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,882.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,564.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,470.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	63,238.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	17,615.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	22,457.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,584.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,713.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	17,544.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,889.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	251.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,759.00	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	8,446.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	710.00	330.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	5,350.00	0.00			
CARDIOLOGY	1,005.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,732.00	0.00			
			TOTAL ANCILLARY	739,799.00	330.00
			TOTAL ACCOMODATIONS	166,733.00	42,047.00
			TOTAL CHARGES	906,532.00	42,377.00

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

DONALSONVILLE HOSPITAL INC
 102 HOSPITAL CIR
 DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
 000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	66,891.00	ADJUSTMENTS	0.00
COVERED CHARGES	49,587.00	CONTRACTUAL ALLOW	623.58
NON-COVERD CHARGES	17,304.00	TOTAL MEDICAID LIAB	48,963.42
		LESS: COB	48,963.42
		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	28		0	18,900.00		17,304.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	28		0	18,900.00		17,304.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	18,900.00		17,304.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,682.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,357.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,099.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	4,147.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,662.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,032.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	708.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	30,687.00	0.00
			TOTAL ACCOMODATIONS	18,900.00	17,304.00
			TOTAL CHARGES	49,587.00	17,304.00

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,583,810.58	ADJUSTMENTS	1,513.46
COVERED CHARGES	1,393,176.58	CONTRACTUAL ALLOW	1,133,724.28
NON-COVERD CHARGES	190,634.00	TOTAL MEDICAID LIAB	259,452.30
		LESS: COB	131.09
		LESS: COPAYMENT	801.00
		REIMBURSEMENT	258,520.21
		ALL OTHER	215,203.85
		FEE SCHEDULE-LAB	43,184.63
		INJECTABLE DRUGS	131.73
		TOTAL NUMBER OF CLAIMS	1,140

DONALSONVILLE HOSPITAL INC
 102 HOSPITAL CIR
 DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
 000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	172,967.66	5,668.00	OTHER LAB	12,099.00	0.00
MED/SURG SUPPLY	130,545.92	78.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	69,305.00	88.00	OTHER THERAPEUTIC SVC	0.00	11,643.00
CT SCAN	87,807.00	15,769.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	591.00	2,974.00	FEE SCHEDULE LAB	487,458.00	31,076.00
EKG/ECG	9,170.00	0.00	MRI SERVICES	20,968.00	3,724.00
IV THERAPY	528.00	59,347.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	126,918.00	16,057.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	691.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,125.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	123,641.00	1,326.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	42,312.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,217.00	3,627.00
RADIOLOGY THERAPEUTIC	0.00	246.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,305.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	405.00	270.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	62,578.00	3,516.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,604.00	330.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,695.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,005.00	2,010.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	28,546.00	31,580.00			
			TOTAL ANCILLARY	1,393,176.58	190,634.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,393,176.58	190,634.00

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

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	33,004.00	ADJUSTMENTS	0.00
COVERED CHARGES	26,799.00	CONTRACTUAL ALLOW	15,813.80
NON-COVERD CHARGES	6,205.00	TOTAL MEDICAID LIAB	10,985.20
		LESS: COB	10,979.20
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 22

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,991.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,809.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,343.00	0.00	OTHER THERAPEUTIC SVC	0.00	659.00
CT SCAN	1,160.00	1,197.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,201.00	400.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	3,109.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	164.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	471.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,032.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	859.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,769.00	840.00			
			TOTAL ANCILLARY	26,799.00	6,205.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	26,799.00	6,205.00

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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DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	150,183.00	ADJUSTMENTS	0.00
COVERED CHARGES	138,572.00	CONTRACTUAL ALLOW	129,062.20
NON-COVERD CHARGES	11,611.00	TOTAL MEDICAID LIAB	9,509.80
		LESS: COB	0.00
		LESS: COPAYMENT	288.00
		REIMBURSEMENT	9,221.80
		TOTAL NUMBER OF CLAIMS	170

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,998.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	775.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,921.00	0.00	OTHER THERAPEUTIC SVC	0.00	5,497.00
CT SCAN	12,846.00	2,043.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	38,589.00	1,475.00
EKG/ECG	700.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	355.00	339.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	61,523.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	745.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,865.00	1,239.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	273.00			
			TOTAL ANCILLARY	138,572.00	11,611.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	138,572.00	11,611.00

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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DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/15	THROUGH	06/30/16
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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,126.00	ADJUSTMENTS	0.00
COVERED CHARGES	28,273.00	CONTRACTUAL ALLOW	22,727.77
NON-COVERD CHARGES	853.00	TOTAL MEDICAID LIAB	5,545.23
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	5,542.23

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
SUMMARY TYPE VIII

Run Date: 08/24/2017
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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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
 Run Time: 04:05:22
 Page: 1

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 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,965,449.65	ADJUSTMENTS	2,452,641.04
COVERED CHARGES	12,641,410.20	CONTRACTUAL ALLOW	8,486,160.18
NON-COVERD CHARGES	1,324,039.45	TOTAL MEDICAID LIAB	4,155,250.02
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,155,250.02

TOTAL NUMBER OF ADMISSIONS 59

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,216		0	2,915,719.00		254,393.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,216		0	2,915,719.00		254,393.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	83		0	236,778.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		281	0.00		405,099.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	83		281	236,778.00		405,099.00
TOTAL ACCOMODATIONS	2,299		281	3,152,497.00		659,492.00

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 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,020,531.40	41,253.50	OTHER LAB	110,345.00	2,000.00
MED/SURG SUPPLY	1,945,383.73	322,548.00	RECREATIONAL THERAPY	2,660.00	0.00
LABORATORY-GENERAL	277,482.00	33,898.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	111,245.31	0.00	OTHER THERAPEUTIC SVC	14,526.00	5,713.00
CT SCAN	73,433.00	7,600.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	722,167.00	56,456.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	5,776.00	0.00	MRI SERVICES	13,045.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	975,432.34	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,043,386.00	32,359.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,004.78	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	62,235.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,079,539.15	35,643.95
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	777,528.00	50,085.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	224,207.04	6,868.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	27,862.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,048.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,780.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	812.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,061.45	0.00			
AMBULATORY SURGERY	39,480.00	7,888.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,178.00	0.00			
			TOTAL ANCILLARY	9,488,913.20	664,547.45
			TOTAL ACCOMODATIONS	3,152,497.00	659,492.00
			TOTAL CHARGES	12,641,410.20	1,324,039.45

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

SHEPHERD CENTER
 2020 PEACHTREE RD NW
 ATLANTA,GA 30309-1426

PROVIDER NUMBER
 000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,676,577.10	ADJUSTMENTS	0.00
COVERED CHARGES	1,495,671.10	CONTRACTUAL ALLOW	398,355.70
NON-COVERD CHARGES	180,906.00	TOTAL MEDICAID LIAB	1,097,315.40
		LESS: COB	1,097,315.40
		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	96		0	135,422.00		5,881.00
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	96		0	135,422.00		5,881.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	27		0	79,686.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		120	0.00		172,197.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	27		120	79,686.00		172,197.00
TOTAL ACCOMODATIONS	123		120	215,108.00		178,078.00

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 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	134,055.80	0.00	OTHER LAB	6,080.00	0.00
MED/SURG SUPPLY	370,225.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	42,606.00	0.00	EDUCATION & TRAINING	7,907.00	0.00
RADIOLOGY-DIAGNOSTIC	12,398.00	0.00	OTHER THERAPEUTIC SVC	0.00	1,407.00
CT SCAN	40,561.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	73,382.00	420.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	620.00	0.00	MRI SERVICES	3,334.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,466.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	307,033.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	148,010.70	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	69,493.00	848.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	54,981.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	153.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,410.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,280,563.10	2,828.00
			TOTAL ACCOMODATIONS	215,108.00	178,078.00
			TOTAL CHARGES	1,495,671.10	180,906.00

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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SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/15 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,071,781.82	ADJUSTMENTS	71,747.86
COVERED CHARGES	4,208,591.57	CONTRACTUAL ALLOW	2,764,203.53
NON-COVERD CHARGES	863,190.25	TOTAL MEDICAID LIAB	1,444,388.04
		LESS: COB	6,619.11
		LESS: COPAYMENT	5,182.41
		REIMBURSEMENT	1,432,586.52
		ALL OTHER	479,737.14
		FEE SCHEDULE-LAB	28,940.81
		INJECTABLE DRUGS	923,908.57
		TOTAL NUMBER OF CLAIMS	1,597

SHEPHERD CENTER
 2020 PEACHTREE RD NW
 ATLANTA,GA 30309-1426

PROVIDER NUMBER
 000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,796.00	25,295.15	OTHER LAB	12,684.00	7,123.00
MED/SURG SUPPLY	58,021.00	0.00	RECREATIONAL THERAPY	380.00	3,268.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	6,901.00
RADIOLOGY-DIAGNOSTIC	21,625.00	2,088.00	OTHER THERAPEUTIC SVC	1,260.00	3,880.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	170,425.00	220,643.04	FEE SCHEDULE LAB	237,068.00	8,666.00
EKG/ECG	1,520.00	0.00	MRI SERVICES	372,612.00	40,146.00
IV THERAPY	3,243.00	63.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,000.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,614,446.55	203,866.05
RADIOLOGY THERAPEUTIC	109,663.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	102,405.02	211,600.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	39,481.00	95,320.01	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	448.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	271,451.00	555.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	9,228.00
OTHER IMAGING SERVICE	15,183.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	5,160.00	2,580.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	167,168.00	21,520.00			
			TOTAL ANCILLARY	4,208,591.57	863,190.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,208,591.57	863,190.25

SHEPHERD CENTER
 2020 PEACHTREE RD NW
 ATLANTA,GA 30309-1426

PROVIDER NUMBER
 000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015247076450	07/07/15 - 07/07/15	09/14/15	0.00	189.00	0.00	0.00	0.00
952	2015247076450	06/29/15 - 06/29/15	09/14/15	0.00	189.00	0.00	0.00	0.00
952	2015247076450	06/22/15 - 06/22/15	09/14/15	0.00	126.00	0.00	0.00	0.00
952	2015247076450	06/08/15 - 06/08/15	09/14/15	0.00	189.00	0.00	0.00	0.00
952	2015247076450	06/01/15 - 06/01/15	09/14/15	0.00	189.00	0.00	0.00	0.00
952	2015247076450	05/26/15 - 05/26/15	09/14/15	0.00	189.00	0.00	0.00	0.00
952	2015247076450	05/19/15 - 05/19/15	09/14/15	0.00	123.00	0.00	0.00	0.00
952	2015247076450	06/22/15 - 06/22/15	09/14/15	0.00	63.00	0.00	0.00	0.00
952	2015247076450	06/19/15 - 06/19/15	09/14/15	0.00	189.00	0.00	0.00	0.00
952	2015260074983	06/11/15 - 06/11/15	09/21/15	0.00	189.00	0.00	0.00	0.00
952	2015276008598	09/08/15 - 09/08/15	10/12/15	0.00	189.00	0.00	0.00	0.00
952	2015276008598	08/31/15 - 08/31/15	10/12/15	0.00	189.00	0.00	0.00	0.00
952	2015276008598	08/20/15 - 08/20/15	10/12/15	0.00	189.00	0.00	0.00	0.00
952	2015276008598	08/10/15 - 08/10/15	10/12/15	0.00	189.00	0.00	0.00	0.00
952	2015276008598	08/06/15 - 08/06/15	10/12/15	0.00	189.00	0.00	0.00	0.00
952	2016077021187	02/04/16 - 02/04/16	03/21/16	0.00	189.00	0.00	0.00	0.00
952	2016077021187	02/02/16 - 02/02/16	03/21/16	0.00	189.00	0.00	0.00	0.00
952	2016077021187	01/06/16 - 01/06/16	03/21/16	0.00	189.00	0.00	0.00	0.00
952	2016077021187	12/30/15 - 12/30/15	03/21/16	0.00	189.00	0.00	0.00	0.00
952	2016077021187	02/12/16 - 02/12/16	03/21/16	0.00	287.00	0.00	0.00	0.00
952	2016077021187	02/10/16 - 02/10/16	03/21/16	0.00	123.00	0.00	0.00	0.00
952	2016077021187	01/28/16 - 01/28/16	03/21/16	0.00	189.00	0.00	0.00	0.00
952	2016077021292	01/18/16 - 01/18/16	03/21/16	0.00	252.00	0.00	0.00	0.00
952	2016077021292	01/15/16 - 01/15/16	03/21/16	0.00	252.00	0.00	0.00	0.00
952	2016077021292	01/14/16 - 01/14/16	03/21/16	0.00	252.00	0.00	0.00	0.00
952	2016077021292	01/11/16 - 01/11/16	03/21/16	0.00	252.00	0.00	0.00	0.00
952	2016077021292	01/04/16 - 01/04/16	03/21/16	0.00	189.00	0.00	0.00	0.00
952	2016077021292	02/03/16 - 02/03/16	03/21/16	0.00	123.00	0.00	0.00	0.00
952	2016077021292	01/28/16 - 01/28/16	03/21/16	0.00	164.00	0.00	0.00	0.00
952	2016077021292	01/27/16 - 01/27/16	03/21/16	0.00	246.00	0.00	0.00	0.00
952	2016077021292	01/08/16 - 01/08/16	03/21/16	0.00	82.00	0.00	0.00	0.00
952	2016077021292	01/07/16 - 01/07/16	03/21/16	0.00	164.00	0.00	0.00	0.00
952	5916203000382	03/15/16 - 03/15/16	07/25/16	0.00	252.00	0.00	0.00	0.00
952	5916203000382	04/08/16 - 04/08/16	07/25/16	0.00	168.00	0.00	0.00	0.00
952	5916203000382	03/18/16 - 03/18/16	07/25/16	0.00	164.00	0.00	0.00	0.00
952	2016347039034	03/28/16 - 03/28/16	12/19/16	0.00	123.00	0.00	0.00	0.00
952	5916357000356	03/18/16 - 03/18/16	12/26/16	0.00	126.00	0.00	0.00	0.00
952	5916357000356	03/14/16 - 03/14/16	12/26/16	0.00	252.00	0.00	0.00	0.00
952	5916357000356	03/15/16 - 03/15/16	12/26/16	0.00	189.00	0.00	0.00	0.00
952	2017013080486	03/18/16 - 03/18/16	01/23/17	0.00	164.00	0.00	0.00	0.00
952	2017013080486	03/15/16 - 03/15/16	01/23/17	0.00	164.00	0.00	0.00	0.00
952	2017013080486	03/11/16 - 03/11/16	01/23/17	0.00	164.00	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

Run Date: 08/24/2017
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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 04/01/15 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

952	2017013080486	03/10/16 - 03/10/16	01/23/17	0.00	164.00	0.00	0.00	0.00
952	2017013080486	03/04/16 - 03/04/16	01/23/17	0.00	328.00	0.00	0.00	0.00
952	2017090079881	03/17/16 - 03/17/16	04/10/17	0.00	63.00	0.00	0.00	0.00
952	2017090079881	03/25/16 - 03/25/16	04/10/17	0.00	123.00	0.00	0.00	0.00
952	2017090079881	03/23/16 - 03/23/16	04/10/17	0.00	246.00	0.00	0.00	0.00
952	2017090079881	03/11/16 - 03/11/16	04/10/17	0.00	123.00	0.00	0.00	0.00
952	2017090079881	03/29/16 - 03/29/16	04/10/17	0.00	189.00	0.00	0.00	0.00
952	2017090079881	03/17/16 - 03/17/16	04/10/17	0.00	126.00	0.00	0.00	0.00
952	2017090079881	03/10/16 - 03/10/16	04/10/17	0.00	189.00	0.00	0.00	0.00
TOTAL				0.00	9,228.00	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

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/15 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	248,726.45	ADJUSTMENTS	0.00
COVERED CHARGES	167,606.85	CONTRACTUAL ALLOW	73,892.66
NON-COVERD CHARGES	81,119.60	TOTAL MEDICAID LIAB	93,714.19
		LESS: COB	93,573.19
		LESS: COPAYMENT	141.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 52

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

SHEPHERD CENTER
 2020 PEACHTREE RD NW
 ATLANTA,GA 30309-1426

PROVIDER NUMBER
 000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	1,489.20	OTHER LAB	0.00	1,120.00
MED/SURG SUPPLY	3,286.00	0.00	RECREATIONAL THERAPY	0.00	456.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	753.00
RADIOLOGY-DIAGNOSTIC	218.00	0.00	OTHER THERAPEUTIC SVC	0.00	398.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,048.00	17,629.00	FEE SCHEDULE LAB	4,864.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,639.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	140,168.85	25,868.40
RADIOLOGY THERAPEUTIC	3,744.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	465.00	21,334.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,173.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	40.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,901.00	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	1,251.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	1,290.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,273.00	8,318.00			
			TOTAL ANCILLARY	167,606.85	81,119.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	167,606.85	81,119.60

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

SHEPHERD CENTER
 2020 PEACHTREE RD NW
 ATLANTA,GA 30309-1426

PROVIDER NUMBER
 000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015271031998	05/29/15 - 05/29/15	10/05/15	0.00	252.00	0.00	2,178.00	0.00
952	2015271031998	05/15/15 - 05/15/15	10/05/15	0.00	164.00	0.00	2,178.00	0.00
952	2015271031998	05/08/15 - 05/08/15	10/05/15	0.00	126.00	0.00	2,178.00	0.00
952	2015271031998	05/07/15 - 05/07/15	10/05/15	0.00	164.00	0.00	2,178.00	0.00
952	2015271031998	05/06/15 - 05/06/15	10/05/15	0.00	252.00	0.00	2,178.00	0.00
952	2015271031998	05/05/15 - 05/05/15	10/05/15	0.00	252.00	0.00	2,178.00	0.00
952	2015271031998	05/04/15 - 05/04/15	10/05/15	0.00	41.00	0.00	2,178.00	0.00
TOTAL				0.00	1,251.00	0.00	15,246.00	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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SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/15	THROUGH	03/31/16
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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SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/15	THROUGH	03/31/16
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 04/01/15 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	36,049.80	ADJUSTMENTS	0.00
COVERED CHARGES	35,762.80	CONTRACTUAL ALLOW	24,619.69
NON-COVERD CHARGES	287.00	TOTAL MEDICAID LIAB	11,143.11
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	11,140.11
		TOTAL NUMBER OF CLAIMS	1

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 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	174.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	1,055.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	8,116.00	0.00
IV THERAPY	217.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	25,532.80	113.00
RADIOLOGY THERAPEUTIC	842.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	35,762.80	287.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	35,762.80	287.00

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

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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	04/01/15	THROUGH	03/31/16
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 NORTH FULTON HOSPITAL, INC
 3000 HOSPITAL BLVD
 ROSWELL,GA 30076-4915

PROVIDER NUMBER 000275976A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,594,061.53	ADJUSTMENTS	186,074.11
COVERED CHARGES	7,534,947.65	CONTRACTUAL ALLOW	6,566,239.66
NON-COVERD CHARGES	59,113.88	TOTAL MEDICAID LIAB	968,707.99
		LESS: COB	10,690.95
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	958,017.04

TOTAL NUMBER OF ADMISSIONS 152

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	311		0	431,855.10		7,163.00
ROUTINE NURSERY	197		0	339,629.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	508		0	771,484.10		7,163.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	175		0	716,163.00		0.00
NICU	1		0	5,077.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	176		0	721,240.00		0.00
TOTAL ACCOMODATIONS	684		0	1,492,724.10		7,163.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

WELLSTAR NORTH FULTON HOSPITAL, INC
 3000 HOSPITAL BLVD
 ROSWELL,GA 30076-4915

PROVIDER NUMBER
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,764,324.20	0.00	OTHER LAB	18,409.80	0.00
MED/SURG SUPPLY	949,314.45	10,809.18	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	720,343.98	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	102,711.90	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	322,182.10	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	52,321.56	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	38,757.60	0.00	MRI SERVICES	73,117.50	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	481,408.00	5,192.90	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	219,604.00	0.00	REHAB THERAPY	240.00	0.00
RESPIRATORY SERVICES	262,489.30	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	105,583.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	45,882.10	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	183,222.20	2,017.80	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	97,250.10	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	40,184.10	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	41,275.92	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	36,348.84	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	2,186.20	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,013.90	0.00	TRAUMA RESPONSE	0.00	9,712.80
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	192,464.40	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	31,178.80	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	23,913.40			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	13,701.00	304.80			
AUDIOLOGY	18,710.70	0.00			
CARDIOLOGY	188,907.20	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,284.60	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	28,806.10	0.00			
			TOTAL ANCILLARY	6,042,223.55	51,950.88
			TOTAL ACCOMODATIONS	1,492,724.10	7,163.00
			TOTAL CHARGES	7,534,947.65	59,113.88

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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WELLSTAR NORTH FULTON HOSPITAL, INC
 3000 HOSPITAL BLVD
 ROSWELL,GA 30076-4915

PROVIDER NUMBER 000275976A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	262,982.23	ADJUSTMENTS	0.00
COVERED CHARGES	262,982.23	CONTRACTUAL ALLOW	206,961.70
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	56,020.53
		LESS: COB	56,020.53
		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	11		0	15,279.00		0.00
ROUTINE NURSERY	3		0	2,151.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	14		0	17,430.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1		0	2,543.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	2,543.00		0.00
TOTAL ACCOMODATIONS	15		0	19,973.00		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

WELLSTAR NORTH FULTON HOSPITAL, INC
 3000 HOSPITAL BLVD
 ROSWELL,GA 30076-4915

PROVIDER NUMBER
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	56,538.10	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	55,932.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,298.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,807.40	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	539.53	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	62,764.70	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	15,146.60	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,330.50	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	9,680.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,556.30	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	12,017.30	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	398.10	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	243,009.23	0.00
			TOTAL ACCOMODATIONS	19,973.00	0.00
			TOTAL CHARGES	262,982.23	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: 08/24/2017
Run Time: 03:51:59
Page: 5

WELLSTAR NORTH FULTON HOSPITAL, INC
3000 HOSPITAL BLVD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,621,117.90	ADJUSTMENTS	22,646.15
COVERED CHARGES	1,477,733.60	CONTRACTUAL ALLOW	1,362,363.94
NON-COVERD CHARGES	143,384.30	TOTAL MEDICAID LIAB	115,369.66
		LESS: COB	376.43
		LESS: COPAYMENT	381.00
		REIMBURSEMENT	114,612.23
		ALL OTHER	101,541.27
		FEE SCHEDULE-LAB	11,443.88
		INJECTABLE DRUGS	1,627.08

TOTAL NUMBER OF CLAIMS 408

WELLSTAR NORTH FULTON HOSPITAL, INC
 3000 HOSPITAL BLVD
 ROSWELL,GA 30076-4915

PROVIDER NUMBER
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	98,962.60	1,105.30	OTHER LAB	7,562.60	0.00
MED/SURG SUPPLY	107,643.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,641.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	72,071.80	1,109.90	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	137,594.10	18,810.30	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,064.60	1,008.37	FEE SCHEDULE LAB	265,582.00	24,536.70
EKG/ECG	16,610.40	692.10	MRI SERVICES	20,744.30	0.00
IV THERAPY	86,646.30	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	60,399.06	24,051.34	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,889.10	1,451.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	19,938.90	0.00	AMBULANCE	0.00	0.00
GI SERVICES	11,770.30	2,113.40	CAST ROOM	0.00	0.00
EMERGENCY ROOM	333,876.20	4,582.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,248.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,440.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	70,379.60	27,969.90
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	771.40	0.03	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	4,552.80	295.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,473.90	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	37,601.40	4,958.40			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	811.30			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	17,847.40	5,132.20			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,969.20	8,591.00			
AMBULATORY SURGERY	33,906.44	10,898.36			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	17,723.80	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	25,903.30	2,186.20			
			TOTAL ANCILLARY	1,477,733.60	143,384.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,477,733.60	143,384.30

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: 08/24/2017
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR NORTH FULTON HOSPITAL, INC
3000 HOSPITAL BLVD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,452.10	ADJUSTMENTS	0.00
COVERED CHARGES	15,452.10	CONTRACTUAL ALLOW	8,832.12
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	6,619.98
		LESS: COB	6,616.98
		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

WELLSTAR NORTH FULTON HOSPITAL, INC
 3000 HOSPITAL BLVD
 ROSWELL,GA 30076-4915

PROVIDER NUMBER
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	281.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	79.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,334.20	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	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,680.70	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,075.80	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	15,452.10	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,452.10	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: 08/24/2017
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WELLSTAR NORTH FULTON HOSPITAL, INC
3000 HOSPITAL BLVD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/16 THROUGH 03/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	137,152.10	ADJUSTMENTS	105.88
COVERED CHARGES	128,452.60	CONTRACTUAL ALLOW	126,326.88
NON-COVERD CHARGES	8,699.50	TOTAL MEDICAID LIAB	2,125.72
		LESS: COB	0.00
		LESS: COPAYMENT	51.00
		REIMBURSEMENT	2,074.72
		TOTAL NUMBER OF CLAIMS	38

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR NORTH FULTON HOSPITAL, INC
 3000 HOSPITAL BLVD
 ROSWELL,GA 30076-4915

PROVIDER NUMBER
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,960.60	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,957.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,603.20	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,374.30	6,807.40	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	23,954.50	745.00
EKG/ECG	2,768.40	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,213.80	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	261.50	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	45,844.90	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	6,256.60	200.90
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,257.50	946.20			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	128,452.60	8,699.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	128,452.60	8,699.50

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: 08/24/2017
Run Time: 03:52:02
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WELLSTAR NORTH FULTON HOSPITAL, INC
3000 HOSPITAL BLVD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/16	THROUGH	03/31/16
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: 08/24/2017
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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR NORTH FULTON HOSPITAL, INC
3000 HOSPITAL BLVD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/16	THROUGH	03/31/16
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: 08/24/2017
Run Time: 03:52:02
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR NORTH FULTON HOSPITAL, INC
3000 HOSPITAL BLVD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/16	THROUGH	03/31/16
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: 08/24/2017
 Run Time: 03:52:09
 Page: 1

WELLSTAR NORTH FULTON HOSPITAL, INC
 3000 HOSPITAL BLVD
 ROSWELL,GA 30076-4915

PROVIDER NUMBER 000275976A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,122,491.90	ADJUSTMENTS	121,040.07
COVERED CHARGES	7,061,913.20	CONTRACTUAL ALLOW	6,126,652.32
NON-COVERD CHARGES	60,578.70	TOTAL MEDICAID LIAB	935,260.88
		LESS: COB	9,923.82
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	925,337.06

TOTAL NUMBER OF ADMISSIONS 143

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	272		0	377,808.00		104.00
ROUTINE NURSERY	159		0	221,943.00		2,340.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	431		0	599,751.00		2,444.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	165		0	565,689.00		0.00
NICU	4		0	20,308.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	169		0	585,997.00		0.00
TOTAL ACCOMODATIONS	600		0	1,185,748.00		2,444.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

WELLSTAR NORTH FULTON HOSPITAL, INC
 3000 HOSPITAL BLVD
 ROSWELL,GA 30076-4915

PROVIDER NUMBER
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,705,708.50	0.00	OTHER LAB	15,535.10	0.00
MED/SURG SUPPLY	777,242.56	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	780,525.28	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	84,176.80	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	423,781.10	3,403.70	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	75,716.54	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	66,467.60	0.00	MRI SERVICES	50,962.40	0.00
IV THERAPY	5,228.30	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	326,371.70	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	278,650.20	0.00	REHAB THERAPY	600.00	0.00
RESPIRATORY SERVICES	252,102.40	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	76,142.20	0.00	AMBULANCE	0.00	0.00
GI SERVICES	87,421.10	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	195,240.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	65,078.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	33,013.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	44,400.91	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	39,354.71	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	14,456.30	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,028.70	0.00	TRAUMA RESPONSE	0.00	32,901.60
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	77,515.90	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	44,356.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	21,829.40			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	59,715.00	0.00			
AUDIOLOGY	16,735.10	0.00			
CARDIOLOGY	252,610.70	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,642.30	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	21,385.90	0.00			
			TOTAL ANCILLARY	5,876,165.20	58,134.70
			TOTAL ACCOMODATIONS	1,185,748.00	2,444.00
			TOTAL CHARGES	7,061,913.20	60,578.70

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: 08/24/2017
 Run Time: 03:52:10
 Page: 3

WELLSTAR NORTH FULTON HOSPITAL, INC
 3000 HOSPITAL BLVD
 ROSWELL,GA 30076-4915

PROVIDER NUMBER 000275976A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,857.50	ADJUSTMENTS	0.00
COVERED CHARGES	10,857.50	CONTRACTUAL ALLOW	7,071.90
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	3,785.60
		LESS: COB	3,785.60
		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	2,778.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2		0	2,778.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	2		0	2,778.00		0.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR NORTH FULTON HOSPITAL, INC
 3000 HOSPITAL BLVD
 ROSWELL,GA 30076-4915

PROVIDER NUMBER
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 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	1,781.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	814.40	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,432.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	8,079.50	0.00
			TOTAL ACCOMODATIONS	2,778.00	0.00
			TOTAL CHARGES	10,857.50	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

Run Date: 08/24/2017
Run Time: 03:52:10
Page: 5

WELLSTAR NORTH FULTON HOSPITAL, INC
3000 HOSPITAL BLVD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/16 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,699,931.80	ADJUSTMENTS	5,366.50
COVERED CHARGES	1,571,540.24	CONTRACTUAL ALLOW	1,453,617.31
NON-COVERD CHARGES	128,391.56	TOTAL MEDICAID LIAB	117,922.93
		LESS: COB	1,551.28
		LESS: COPAYMENT	387.00
		REIMBURSEMENT	115,984.65
		ALL OTHER	105,951.02
		FEE SCHEDULE-LAB	8,605.09
		INJECTABLE DRUGS	1,428.54

TOTAL NUMBER OF CLAIMS 360

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: 08/24/2017
 Run Time: 03:52:10
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WELLSTAR NORTH FULTON HOSPITAL, INC
 3000 HOSPITAL BLVD
 ROSWELL,GA 30076-4915

PROVIDER NUMBER
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	98,587.90	0.00	OTHER LAB	12,028.20	0.00
MED/SURG SUPPLY	115,367.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	52,851.70	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	171,783.50	28,297.20	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	245,591.30	10,854.70
EKG/ECG	23,531.40	692.10	MRI SERVICES	39,476.30	0.00
IV THERAPY	102,716.70	809.30	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	79,755.40	4,370.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,368.80	1,489.60	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	17,753.80	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	295,706.60	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,105.90	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	144,247.60	32,061.40
RADIOLOGY THERAPEUTIC	6,959.80	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,093.10	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,754.40	439.20	TRAUMA RESPONSE	0.00	3,237.60
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	12,547.30	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	39,044.70	5,908.20			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,132.20	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,656.40	16,472.00			
AMBULATORY SURGERY	47,404.04	21,574.06			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	17,723.80	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	21,444.90	1,093.10			
			TOTAL ANCILLARY	1,571,540.24	128,391.56
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,571,540.24	128,391.56

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: 08/24/2017
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR NORTH FULTON HOSPITAL, INC
3000 HOSPITAL BLVD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/16	THROUGH	06/30/16
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: 08/24/2017
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Page: 8

WELLSTAR NORTH FULTON HOSPITAL, INC
3000 HOSPITAL BLVD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/16 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	138,439.00	ADJUSTMENTS	0.00
COVERED CHARGES	128,769.60	CONTRACTUAL ALLOW	126,476.06
NON-COVERD CHARGES	9,669.40	TOTAL MEDICAID LIAB	2,293.54
		LESS: COB	0.00
		LESS: COPAYMENT	51.00
		REIMBURSEMENT	2,242.54
		TOTAL NUMBER OF CLAIMS	41

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR NORTH FULTON HOSPITAL, INC
 3000 HOSPITAL BLVD
 ROSWELL,GA 30076-4915

PROVIDER NUMBER
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,486.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,441.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,337.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,747.20	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	28,298.40	3,456.90
EKG/ECG	2,076.30	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,677.60	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,382.10	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	5,823.10
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	53,353.40	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	4,926.10	389.40
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	3,043.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	128,769.60	9,669.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	128,769.60	9,669.40

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: 08/24/2017
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WELLSTAR NORTH FULTON HOSPITAL, INC
3000 HOSPITAL BLVD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/16	THROUGH	06/30/16
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: 08/24/2017
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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR NORTH FULTON HOSPITAL, INC
3000 HOSPITAL BLVD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/16 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	46,635.80	ADJUSTMENTS	0.00
COVERED CHARGES	43,232.10	CONTRACTUAL ALLOW	37,791.50
NON-COVERD CHARGES	3,403.70	TOTAL MEDICAID LIAB	5,440.60
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,440.60

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: 08/24/2017
 Run Time: 03:52:12
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SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR NORTH FULTON HOSPITAL, INC
 3000 HOSPITAL BLVD
 ROSWELL,GA 30076-4915

PROVIDER NUMBER
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	474.30	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	202.00	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	4,205.50	3,403.70	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,188.60	0.00
EKG/ECG	692.10	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,001.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,862.40	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	31,090.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	43,232.10	3,403.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	43,232.10	3,403.70

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: 08/24/2017
Run Time: 03:52:12
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR NORTH FULTON HOSPITAL, INC
3000 HOSPITAL BLVD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/16	THROUGH	06/30/16
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: 08/24/2017
 Run Time: 02:34:31
 Page: 1

COLISEUM NORTHSIDE HOSPITAL
 400 CHARTER BLVD
 MACON,GA 31210-4831

PROVIDER NUMBER 000295358A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,021,294.62	ADJUSTMENTS	198,211.51
COVERED CHARGES	6,806,311.87	CONTRACTUAL ALLOW	5,502,645.29
NON-COVERD CHARGES	214,982.75	TOTAL MEDICAID LIAB	1,303,666.58
		LESS: COB	12,265.06
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,291,401.52

TOTAL NUMBER OF ADMISSIONS 138

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	412		0	389,588.00		106,938.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	412		0	389,588.00		106,938.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	205		0	624,491.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	205		0	624,491.00		0.00
TOTAL ACCOMODATIONS	617		0	1,014,079.00		106,938.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	507,299.50	0.00	OTHER LAB	35,711.75	0.00
MED/SURG SUPPLY	256,024.75	352.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,036,950.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	212,572.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	312,510.25	69,721.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	69,062.53	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	33,710.75	0.00	MRI SERVICES	74,392.25	0.00
IV THERAPY	35,427.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	634,905.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	261,153.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	239,192.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	30,910.75	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	212,425.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	84,432.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	37,971.00
LABORATORY PATHOLOGIC	13,254.25	0.00	INJECTABLE DRUGS	1,013,569.03	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	41,244.11	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,227.45	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	78,704.25	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,294.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	327,750.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	53,155.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	40,816.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	13,075.25	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	160,443.75	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,892.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,124.50	0.00			
			TOTAL ANCILLARY	5,792,232.87	108,044.75
			TOTAL ACCOMODATIONS	1,014,079.00	106,938.00
			TOTAL CHARGES	6,806,311.87	214,982.75

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 07/01/15 THROUGH 06/30/16
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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COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,888,399.59	ADJUSTMENTS	16,858.52
COVERED CHARGES	6,440,660.15	CONTRACTUAL ALLOW	5,732,275.27
NON-COVERD CHARGES	447,739.44	TOTAL MEDICAID LIAB	708,384.88
		LESS: COB	2,297.53
		LESS: COPAYMENT	888.00
		REIMBURSEMENT	705,199.35
		ALL OTHER	648,266.87
		FEE SCHEDULE-LAB	52,876.24
		INJECTABLE DRUGS	4,056.24
		TOTAL NUMBER OF CLAIMS	2,148

COLISEUM NORTHSIDE HOSPITAL
 400 CHARTER BLVD
 MACON,GA 31210-4831

PROVIDER NUMBER
 000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	156,452.75	0.00	OTHER LAB	40,385.75	0.00
MED/SURG SUPPLY	53,389.50	702.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	10,046.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	794,130.00	725.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	872,835.75	210,237.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	37,053.00	28,883.50	FEE SCHEDULE LAB	1,203,381.96	32,955.57
EKG/ECG	92,647.50	0.00	MRI SERVICES	81,438.50	5,555.75
IV THERAPY	281,591.00	735.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	350,686.99	56,845.01	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	23,438.25	6,354.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	128,284.00	1,094.50	AMBULANCE	0.00	0.00
GI SERVICES	16,602.63	5,684.12	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,776,657.25	3,138.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	67,422.75	2,189.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	36,802.82	16,609.74
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	14,317.25	3,797.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,678.75	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	5,558.25	2,248.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	40,074.00	1,567.25
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	103,045.75	41,704.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,264.00	650.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	12,235.50	4,006.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,812.75	8,440.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	220,922.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	25,229.75	1,891.00			
			TOTAL ANCILLARY	6,440,660.15	447,739.44
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,440,660.15	447,739.44

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

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	126,412.50	ADJUSTMENTS	0.00
COVERED CHARGES	108,298.75	CONTRACTUAL ALLOW	71,021.77
NON-COVERD CHARGES	18,113.75	TOTAL MEDICAID LIAB	37,276.98
		LESS: COB	37,255.98
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 40

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,302.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	384.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,218.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,297.00	9,364.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	23,238.75	29.00
EKG/ECG	1,924.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,217.50	265.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,858.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	182.75	274.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	6,808.75	CAST ROOM	0.00	0.00
EMERGENCY ROOM	30,990.75	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	570.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,263.75	1,373.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,850.25	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	108,298.75	18,113.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	108,298.75	18,113.75

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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COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	619,886.00	ADJUSTMENTS	108.88
COVERED CHARGES	612,787.00	CONTRACTUAL ALLOW	591,753.56
NON-COVERD CHARGES	7,099.00	TOTAL MEDICAID LIAB	21,033.44
		LESS: COB	0.00
		LESS: COPAYMENT	693.00
		REIMBURSEMENT	20,340.44
		TOTAL NUMBER OF CLAIMS	376

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,720.00	0.00	OTHER LAB	1,587.75	0.00
MED/SURG SUPPLY	667.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	3,617.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	86,775.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	36,471.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	127,728.00	1,775.25
EKG/ECG	1,532.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	27,508.25	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	561.00	249.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	312,006.50	607.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,694.50	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	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,534.50	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	612,787.00	7,099.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	612,787.00	7,099.00

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

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,340.00	ADJUSTMENTS	0.00
COVERED CHARGES	11,340.00	CONTRACTUAL ALLOW	6,662.88
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	4,677.12
		LESS: COB	4,671.12
		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

COLISEUM NORTHSIDE HOSPITAL
 400 CHARTER BLVD
 MACON,GA 31210-4831

PROVIDER NUMBER
 000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	282.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	21.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,863.50	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	3,325.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,817.25	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	31.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	11,340.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,340.00	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

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	107,999.25	ADJUSTMENTS	0.00
COVERED CHARGES	106,476.50	CONTRACTUAL ALLOW	95,755.46
NON-COVERD CHARGES	1,522.75	TOTAL MEDICAID LIAB	10,721.04
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	10,721.04

TOTAL NUMBER OF CLAIMS 2

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,246.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,608.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,357.50	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	852.75	FEE SCHEDULE LAB	1,084.00	0.00
EKG/ECG	392.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	57,633.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	24,299.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,547.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	179.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	670.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	8,178.25	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	951.50	0.00			
			TOTAL ANCILLARY	106,476.50	1,522.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	106,476.50	1,522.75

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: 08/24/2017
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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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
 Run Time: 03:58:17
 Page: 1

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	922,676.03	ADJUSTMENTS	46,789.93
COVERED CHARGES	913,147.53	CONTRACTUAL ALLOW	669,065.74
NON-COVERD CHARGES	9,528.50	TOTAL MEDICAID LIAB	244,081.79
		LESS: COB	737.88
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	243,343.91

TOTAL NUMBER OF ADMISSIONS 20

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	65		0	58,500.00		4,680.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	65		0	58,500.00		4,680.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	65		0	58,500.00		4,680.00

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

NORTHSIDE MEDICAL CENTER
 100 FRIST CT
 COLUMBUS,GA 31909-3578

PROVIDER NUMBER
 000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,426.79	0.00	OTHER LAB	2,006.25	0.00
MED/SURG SUPPLY	68,849.75	3,946.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	25,524.40	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,648.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	11,309.81	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,632.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	253,310.59	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,162.11	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	49,604.60	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	35,300.84	0.00	DRUG-SPECIFIC/HOME IV	0.00	902.00
LABORATORY PATHOLOGIC	402.00	0.00	INJECTABLE DRUGS	74,624.95	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,397.94	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	290,246.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,611.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,590.25	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	854,647.53	4,848.50
			TOTAL ACCOMODATIONS	58,500.00	4,680.00
			TOTAL CHARGES	913,147.53	9,528.50

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

NORTHSIDE MEDICAL CENTER
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/15	THROUGH	06/30/16
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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	840,092.01	ADJUSTMENTS	4,545.03
COVERED CHARGES	811,757.70	CONTRACTUAL ALLOW	657,327.43
NON-COVERD CHARGES	28,334.31	TOTAL MEDICAID LIAB	154,430.27
		LESS: COB	950.57
		LESS: COPAYMENT	402.00
		REIMBURSEMENT	153,077.70
		ALL OTHER	148,697.59
		FEE SCHEDULE-LAB	2,735.56
		INJECTABLE DRUGS	1,644.55

TOTAL NUMBER OF CLAIMS 130

SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE MEDICAL CENTER
 100 FRIST CT
 COLUMBUS,GA 31909-3578

PROVIDER NUMBER
 000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,709.47	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	67,446.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,010.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,170.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	12,118.27	6,010.01	FEE SCHEDULE LAB	23,703.51	460.00
EKG/ECG	3,876.00	0.00	MRI SERVICES	34,476.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	312,222.34	15,429.05	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	388.46	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	108,963.80	0.00	AMBULANCE	0.00	0.00
GI SERVICES	41,500.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	65,887.70	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,199.50	3,971.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,026.92	237.75	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	51,669.50	1,800.00
LITHOTRIPSY	41,505.00	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	5,079.23	426.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	811,757.70	28,334.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	811,757.70	28,334.31

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,973.94	ADJUSTMENTS	0.00
COVERED CHARGES	11,973.94	CONTRACTUAL ALLOW	8,504.49
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	3,469.45
		LESS: COB	3,466.45
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	95.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	119.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	203.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	28.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,768.20	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	1,382.99	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	75.50	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	8,301.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	11,973.94	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,973.94	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: 08/24/2017
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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	07/01/15	THROUGH	06/30/16
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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,669.07	ADJUSTMENTS	0.00
COVERED CHARGES	29,669.07	CONTRACTUAL ALLOW	24,163.07
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	5,506.00
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	5,503.00

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	525.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,139.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	56.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,686.95	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,803.88	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,382.99	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	132.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	8,040.00	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	29,669.07	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	29,669.07	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

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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	07/01/15	THROUGH	06/30/16
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: 08/24/2017
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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	09/01/15	THROUGH	08/31/16
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

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

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

Run Date: 08/24/2017
Run Time: 02:55:02
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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	09/01/15	THROUGH	08/31/16
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: 08/24/2017
Run Time: 02:55:02
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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 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,951.92	ADJUSTMENTS	2,750.09
COVERED CHARGES	7,951.92	CONTRACTUAL ALLOW	5,198.83
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	2,753.09
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	2,750.09
		ALL OTHER	2,749.90
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.19

TOTAL NUMBER OF CLAIMS 1

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: 08/24/2017
 Run Time: 02:55:02
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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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 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	33.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,299.00	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	584.92	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,951.92	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,951.92	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: 08/24/2017
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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	09/01/15	THROUGH	08/31/16
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: 08/24/2017
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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	09/01/15	THROUGH	08/31/16
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

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	09/01/15	THROUGH	08/31/16
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	09/01/15	THROUGH	08/31/16
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: 08/24/2017
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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	09/01/15	THROUGH	08/31/16
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

HEALTHSOUTH WALTON REHABILITATION HOSPITAL, LLC
 1355 INDEPENDENCE DR
 AUGUSTA,GA 30901-1037

PROVIDER NUMBER
 000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	563,266.69	ADJUSTMENTS	99,926.74
COVERED CHARGES	334,638.69	CONTRACTUAL ALLOW	97,434.83
NON-COVERD CHARGES	228,628.00	TOTAL MEDICAID LIAB	237,203.86
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	237,203.86

TOTAL NUMBER OF ADMISSIONS 30

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	65		240	60,033.00		228,628.00
ROUTINE NURSERY	0		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		240	60,033.00		228,628.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	65		240	60,033.00		228,628.00

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

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

Run Date: 08/24/2017
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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 04/01/15 THROUGH 03/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	87,690.48	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,085.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,244.88	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,589.13	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	73,155.20	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	8,368.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	75,998.30	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	13,474.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	274,605.69	0.00
			TOTAL ACCOMODATIONS	60,033.00	228,628.00
			TOTAL CHARGES	334,638.69	228,628.00

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

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

Run Date: 08/24/2017
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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	04/01/15	THROUGH	03/31/16
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: 08/24/2017
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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 04/01/15 THROUGH 03/31/16
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

Run Date: 08/24/2017
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HEALTHSOUTH WALTON REHABILITATION HOSPITAL, LLC
1355 INDEPENDENCE DR
AUGUSTA,GA 30901-1037

PROVIDER NUMBER
000368387A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/15	THROUGH	03/31/16
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	04/01/15	THROUGH	03/31/16
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	04/01/15	THROUGH	03/31/16
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	04/01/15	THROUGH	03/31/16
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: 08/24/2017
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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	04/01/15	THROUGH	03/31/16
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000472513A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/15 THROUGH 06/27/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,289,834.69	ADJUSTMENTS	567,443.08
COVERED CHARGES	10,153,581.69	CONTRACTUAL ALLOW	7,727,873.86
NON-COVERD CHARGES	3,136,253.00	TOTAL MEDICAID LIAB	2,425,707.83
		LESS: COB	21,612.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,404,095.42

TOTAL NUMBER OF ADMISSIONS 58

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	478		737	837,456.00		1,739,224.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	478		737	837,456.00		1,739,224.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	834		0	2,152,214.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	834		0	2,152,214.00		0.00
TOTAL ACCOMODATIONS	1,312		737	2,989,670.00		1,739,224.00

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

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

Run Date: 08/24/2017
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000472513A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/15 THROUGH 06/27/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,277,794.96	1,494.00	OTHER LAB	14,052.00	0.00
MED/SURG SUPPLY	832,325.78	4,398.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,193,478.00	41,745.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	134,262.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	58,884.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	92,473.08	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	23,460.00	0.00	MRI SERVICES	10,314.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	167,489.00	1,383.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,860,067.00	1,348,009.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	42,040.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,238.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	24,395.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	98,606.09	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	137,617.17	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	54,540.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,767.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	52,961.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	14,080.05	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	10,777.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	57,290.56	0.00			
			TOTAL ANCILLARY	7,163,911.69	1,397,029.00
			TOTAL ACCOMODATIONS	2,989,670.00	1,739,224.00
			TOTAL CHARGES	10,153,581.69	3,136,253.00

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

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

Run Date: 08/24/2017
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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
000472513A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/15 THROUGH 06/27/16
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: 08/24/2017
Run Time: 03:33:12
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SELECT SPECIALTY HOSPITAL - MIDTOWN ATLANTA, LLC
705 JUNIPER ST NE
ATLANTA,GA 30308-1307

PROVIDER NUMBER
000472513A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/15	THROUGH	06/27/16
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

Run Date: 08/24/2017
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER
000472513A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/15	THROUGH	06/27/16
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: 08/24/2017
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SELECT SPECIALTY HOSPITAL - MIDTOWN ATLANTA, LLC
705 JUNIPER ST NE
ATLANTA,GA 30308-1307

PROVIDER NUMBER
000472513A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/15	THROUGH	06/27/16
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: 08/24/2017
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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
000472513A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/15	THROUGH	06/27/16
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: 08/24/2017
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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER
000472513A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/15	THROUGH	06/27/16
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: 08/24/2017
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER
000472513A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/15	THROUGH	06/27/16
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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,551,667.35	ADJUSTMENTS	126,722.38
COVERED CHARGES	10,514,470.75	CONTRACTUAL ALLOW	7,854,394.67
NON-COVERD CHARGES	37,196.60	TOTAL MEDICAID LIAB	2,660,076.08
		LESS: COB	15,211.38
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,644,864.70

TOTAL NUMBER OF ADMISSIONS 394

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,104		0	1,401,400.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,104		0	1,401,400.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	1,104		0	1,401,400.00		0.00

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	771,287.75	0.00	OTHER LAB	12,616.00	0.00
MED/SURG SUPPLY	187,970.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	776,201.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	209,331.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,856.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,095.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,660.00	0.00	MRI SERVICES	49,056.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	2,397.40
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,033,751.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	887,210.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	376.00	499.00	INJECTABLE DRUGS	262.00	0.00
RADIOLOGY THERAPEUTIC	218.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,328.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	120.00	24,714.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	28,715.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	75,048.00	1,911.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	36,043.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,926.50	7,675.20			
			TOTAL ANCILLARY	9,113,070.75	37,196.60
			TOTAL ACCOMODATIONS	1,401,400.00	0.00
			TOTAL CHARGES	10,514,470.75	37,196.60

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

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	01/01/16	THROUGH	12/31/16
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: 08/24/2017
Run Time: 02:22:40
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,540,687.30	ADJUSTMENTS	252,056.48
COVERED CHARGES	18,348,014.30	CONTRACTUAL ALLOW	14,412,038.63
NON-COVERD CHARGES	1,192,673.00	TOTAL MEDICAID LIAB	3,935,975.67
		LESS: COB	10,046.18
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	3,925,926.49
		ALL OTHER	3,559,223.45
		FEE SCHEDULE-LAB	150,833.40
		INJECTABLE DRUGS	215,869.64
		TOTAL NUMBER OF CLAIMS	11,676

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	285,821.75	12.25	OTHER LAB	506,611.00	0.00
MED/SURG SUPPLY	500,592.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	644,291.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	83,381.00	11,142.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,830,341.00	318,966.00
EKG/ECG	29,550.00	290.00	MRI SERVICES	0.00	0.00
IV THERAPY	846.00	0.00	PROFESSIONAL FEES	0.00	505.70
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	977,803.75	355,337.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,197,556.00	266,630.50	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	635,831.50	84,152.25
RADIOLOGY THERAPEUTIC	21,146.00	436.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,839,990.00	143,513.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	70,477.00	4,493.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	574,986.00	4,708.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	516.00	0.00			
CARDIOLOGY	57,078.00	1,901.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	91,196.30	586.30			
			TOTAL ANCILLARY	18,348,014.30	1,192,673.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,348,014.30	1,192,673.00

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

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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	88,154.90	ADJUSTMENTS	0.00
COVERED CHARGES	78,661.00	CONTRACTUAL ALLOW	53,832.01
NON-COVERD CHARGES	9,493.90	TOTAL MEDICAID LIAB	24,828.99
		LESS: COB	24,828.99
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 51

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,397.75	0.00	OTHER LAB	4,654.00	0.00
MED/SURG SUPPLY	2,641.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,968.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,158.00	123.00
EKG/ECG	290.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	313.40
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,811.00	4,110.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	31,713.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	352.25	3,257.50
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	14,676.00	1,690.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	78,661.00	9,493.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	78,661.00	9,493.90

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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,150,348.50	ADJUSTMENTS	2,125.72
COVERED CHARGES	2,145,194.00	CONTRACTUAL ALLOW	2,053,580.71
NON-COVERD CHARGES	5,154.50	TOTAL MEDICAID LIAB	91,613.29
		LESS: COB	1,376.13
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	90,225.16
		TOTAL NUMBER OF CLAIMS	1,614

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38,285.75	24.25	OTHER LAB	1,604.00	0.00
MED/SURG SUPPLY	29,121.50	287.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	50,039.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	186,869.00	1,392.00
EKG/ECG	4,330.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	192.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	22,187.00	1,497.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,796,154.00	290.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,985.75	448.25
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	1,433.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,185.00	1,024.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,145,194.00	5,154.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,145,194.00	5,154.50

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
 000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	147.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,712.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	95.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,471.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,330.25	95.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,330.25	95.00

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: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	173,443.00	ADJUSTMENTS	9,244.31
COVERED CHARGES	173,443.00	CONTRACTUAL ALLOW	71,755.59
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	101,687.41
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	101,687.41
		TOTAL NUMBER OF CLAIMS	11

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 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	189.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	165,514.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,435.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,305.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	173,443.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	173,443.00	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: 08/24/2017
Run Time: 02:24:06
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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	01/01/16	THROUGH	12/31/16
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: 08/24/2017
 Run Time: 03:51:16
 Page: 1

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	32,965.54	ADJUSTMENTS	8,103.44
COVERED CHARGES	32,529.54	CONTRACTUAL ALLOW	15,972.16
NON-COVERD CHARGES	436.00	TOTAL MEDICAID LIAB	16,557.38
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	16,557.38

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7		0	3,276.00		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	7		0	3,276.00		180.00
SPECIAL CARE SERVICES						
CCU	3		0	1,980.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	3		0	1,980.00		0.00
TOTAL ACCOMODATIONS	10		0	5,256.00		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: 08/24/2017
 Run Time: 03:51:16
 Page: 2

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,758.37	0.00	OTHER LAB	500.00	0.00
MED/SURG SUPPLY	2,073.06	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,213.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	441.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,200.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,574.30	256.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,250.48	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	263.33	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	27,273.54	256.00
			TOTAL ACCOMODATIONS	5,256.00	180.00
			TOTAL CHARGES	32,529.54	436.00

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

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 07/01/15 THROUGH 06/30/16
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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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	632,369.85	ADJUSTMENTS	42,386.51
COVERED CHARGES	605,219.32	CONTRACTUAL ALLOW	359,014.30
NON-COVERD CHARGES	27,150.53	TOTAL MEDICAID LIAB	246,205.02
		LESS: COB	94.00
		LESS: COPAYMENT	360.00
		REIMBURSEMENT	245,751.02
		ALL OTHER	230,826.68
		FEE SCHEDULE-LAB	14,213.21
		INJECTABLE DRUGS	711.13

TOTAL NUMBER OF CLAIMS 630

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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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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,236.27	548.03	OTHER LAB	11,108.99	0.00
MED/SURG SUPPLY	9,150.81	178.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	44,098.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	84,995.00	10,200.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	182.00	0.00	FEE SCHEDULE LAB	108,211.75	7,700.50
EKG/ECG	6,400.00	0.00	MRI SERVICES	1,125.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	24,184.44	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,476.96	1,140.98	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	29,170.60	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	234,146.88	1,875.92	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,337.95	3,861.10
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	677.00	116.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	968.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,200.00
OTHER IMAGING SERVICE	10,270.67	46.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	459.00	283.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	750.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,270.00	0.00			
			TOTAL ANCILLARY	605,219.32	27,150.53
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	605,219.32	27,150.53

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: 08/24/2017
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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5916110001041	02/29/16 - 02/29/16	04/25/16	0.00	1,200.00	0.00	0.00	0.00
TOTAL				0.00	1,200.00	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

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,616.98	ADJUSTMENTS	0.00
COVERED CHARGES	5,638.76	CONTRACTUAL ALLOW	1,770.51
NON-COVERD CHARGES	2,978.22	TOTAL MEDICAID LIAB	3,868.25
		LESS: COB	3,868.25
		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

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	104.22	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	135.36	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	297.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,700.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,715.00	34.00
EKG/ECG	128.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	128.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,303.40	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	60.00	12.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	5,638.76	2,978.22
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,638.76	2,978.22

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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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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	60,385.01	ADJUSTMENTS	141.00
COVERED CHARGES	58,988.87	CONTRACTUAL ALLOW	53,988.87
NON-COVERD CHARGES	1,396.14	TOTAL MEDICAID LIAB	5,000.00
		LESS: COB	0.00
		LESS: COPAYMENT	177.47
		REIMBURSEMENT	4,822.53
		TOTAL NUMBER OF CLAIMS	100

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,045.50	271.41	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	236.57	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,272.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,045.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,166.00	297.00
EKG/ECG	128.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	444.31	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	42,441.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,210.49	409.73
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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	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	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	58,988.87	1,396.14
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	58,988.87	1,396.14

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

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	07/01/15	THROUGH	06/30/16
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

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,101.08	ADJUSTMENTS	0.00
COVERED CHARGES	22,715.08	CONTRACTUAL ALLOW	17,945.70
NON-COVERD CHARGES	386.00	TOTAL MEDICAID LIAB	4,769.38
		LESS: COB	0.00
		LESS: COPAYMENT	54.00
		REIMBURSEMENT	4,715.38

TOTAL NUMBER OF CLAIMS 1

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 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	334.74	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	637.00	170.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	18,669.34	216.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,074.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	22,715.08	386.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	22,715.08	386.00

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: 08/24/2017
Run Time: 03:51:19
Page: 14

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	07/01/15	THROUGH	06/30/16
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

PIEDMONT FAYETTE HOSPITAL
 1255 HIGHWAY 54 W
 FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER 000755323A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,631,847.44	ADJUSTMENTS	1,824,193.59
COVERED CHARGES	22,935,358.03	CONTRACTUAL ALLOW	17,212,033.49
NON-COVERD CHARGES	696,489.41	TOTAL MEDICAID LIAB	5,723,324.54
		LESS: COB	106,741.90
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,616,582.64

TOTAL NUMBER OF ADMISSIONS 607

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,878		0	1,875,986.00		309,179.00
ROUTINE NURSERY	465		2	594,284.00		2,543.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,343		2	2,470,270.00		311,722.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	698		0	2,019,571.00		0.00
NICU	120		0	228,575.00		107,136.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	818		0	2,248,146.00		107,136.00
TOTAL ACCOMODATIONS	3,161		2	4,718,416.00		418,858.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,802,302.62	25,853.88	OTHER LAB	157,085.00	0.00
MED/SURG SUPPLY	488,172.52	10,237.53	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,207,991.00	59,721.00	EDUCATION & TRAINING	7,020.00	0.00
RADIOLOGY-DIAGNOSTIC	490,217.00	10,274.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,403,595.00	4,873.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	300,986.56	1,871.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	226,411.00	0.00	MRI SERVICES	298,359.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,377,204.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	394,422.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,284,723.00	83,802.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	170,594.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	213,884.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,507,674.00	399.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	284,776.00	1,815.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	187,892.00	0.00	INJECTABLE DRUGS	390.00	0.00
RADIOLOGY THERAPEUTIC	74,788.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	150,566.17	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	60,525.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	423,990.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	41,787.00	40,561.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	270,019.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	246,640.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	439,936.00	23,221.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	78,469.00	12,462.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	453,991.00	2,541.00			
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	122,696.16	0.00			
			TOTAL ANCILLARY	18,216,942.03	277,631.41
			TOTAL ACCOMODATIONS	4,718,416.00	418,858.00
			TOTAL CHARGES	22,935,358.03	696,489.41

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

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

Run Date: 08/24/2017
 Run Time: 03:18:19
 Page: 3

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	749,993.15	ADJUSTMENTS	0.00
COVERED CHARGES	732,302.15	CONTRACTUAL ALLOW	434,543.52
NON-COVERD CHARGES	17,691.00	TOTAL MEDICAID LIAB	297,758.63
		LESS: COB	297,758.63
		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	89		0	89,356.00		16,218.00
ROUTINE NURSERY	24		0	30,530.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	113		0	119,886.00		16,218.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	8		0	23,411.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	8		0	23,411.00		0.00
TOTAL ACCOMODATIONS	121		0	143,297.00		16,218.00

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	104,188.80	0.00	OTHER LAB	1,811.00	0.00
MED/SURG SUPPLY	29,596.43	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	68,363.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,143.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,799.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,003.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,479.00	0.00	MRI SERVICES	9,385.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	82,701.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	106,319.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,599.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,646.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	9,037.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,943.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	46,874.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	4,268.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,848.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,672.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	18,763.72	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,751.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,466.00	1,473.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,349.20	0.00			
			TOTAL ANCILLARY	589,005.15	1,473.00
			TOTAL ACCOMODATIONS	143,297.00	16,218.00
			TOTAL CHARGES	732,302.15	17,691.00

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: 08/24/2017
Run Time: 03:18:21
Page: 5

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,957,794.70	ADJUSTMENTS	568,801.62
COVERED CHARGES	15,889,270.84	CONTRACTUAL ALLOW	13,741,955.29
NON-COVERD CHARGES	3,068,523.86	TOTAL MEDICAID LIAB	2,147,315.55
		LESS: COB	79,282.86
		LESS: COPAYMENT	4,224.03
		REIMBURSEMENT	2,063,808.66
		ALL OTHER	1,873,645.10
		FEE SCHEDULE-LAB	141,066.51
		INJECTABLE DRUGS	49,097.05

TOTAL NUMBER OF CLAIMS 4,082

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	282,498.89	87,815.60	OTHER LAB	206,106.00	1,355.00
MED/SURG SUPPLY	349,689.22	54,835.98	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,252.00	EDUCATION & TRAINING	0.00	720.00
RADIOLOGY-DIAGNOSTIC	819,661.00	13,874.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,143,366.00	940,318.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	13,708.00	12,060.00	FEE SCHEDULE LAB	2,237,121.40	147,494.00
EKG/ECG	382,568.00	9,860.00	MRI SERVICES	187,112.00	35,881.00
IV THERAPY	165,057.00	711.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	684,270.00	218,044.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	79,683.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	78,742.00	30,552.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	132,540.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	419,566.00	104,595.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,034,744.00	170,831.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	230,909.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	619.00	INJECTABLE DRUGS	417,835.62	210,863.63
RADIOLOGY THERAPEUTIC	225,398.00	180,196.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	553.00	11,212.04	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,206.00	6,238.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	23,555.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	89,608.00	9,397.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	29,337.78	85,346.61
LITHOTRIPSY	49,154.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	488,601.00	388,684.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	132,518.00	48,609.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	142,711.00	46,543.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	381,373.00	213,360.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	21,613.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	459,020.93	13,702.00			
			TOTAL ANCILLARY	15,889,270.84	3,068,523.86
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,889,270.84	3,068,523.86

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: 08/24/2017
Run Time: 03:19:10
Page: 7

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	583,534.78	ADJUSTMENTS	0.00
COVERED CHARGES	391,625.67	CONTRACTUAL ALLOW	257,131.67
NON-COVERD CHARGES	191,909.11	TOTAL MEDICAID LIAB	134,494.00
		LESS: COB	134,357.49
		LESS: COPAYMENT	136.51
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 115

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,213.76	166.40	OTHER LAB	3,076.00	0.00
MED/SURG SUPPLY	6,312.78	137.28	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,519.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,889.00	59,303.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	61,923.00	7,178.00
EKG/ECG	9,860.00	986.00	MRI SERVICES	0.00	3,714.00
IV THERAPY	1,455.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	34,575.00	7,927.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	10,607.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	594.00	3,443.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,468.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	8,075.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	132,598.00	3,150.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,181.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,539.13	1,899.43
RADIOLOGY THERAPEUTIC	36,331.00	11,424.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	762.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	612.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	20,948.00	22,923.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,949.00	1,473.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	10,210.00	67,573.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,540.00	0.00			
			TOTAL ANCILLARY	391,625.67	191,909.11
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	391,625.67	191,909.11

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: 08/24/2017
Run Time: 03:19:12
Page: 9

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,018,092.79	ADJUSTMENTS	1,126.02
COVERED CHARGES	890,790.82	CONTRACTUAL ALLOW	864,738.04
NON-COVERD CHARGES	127,301.97	TOTAL MEDICAID LIAB	26,052.78
		LESS: COB	1,552.85
		LESS: COPAYMENT	720.66
		REIMBURSEMENT	23,779.27
		TOTAL NUMBER OF CLAIMS	439

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,282.56	332.80	OTHER LAB	8,777.00	0.00
MED/SURG SUPPLY	7,723.28	540.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	60,566.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	57,195.00	70,227.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	139,791.00	9,526.00
EKG/ECG	21,199.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,750.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,635.00	549.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,185.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	523,371.00	7,346.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,578.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,451.98	1,331.52
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	209.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	1,109.85
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	34,887.00	36,130.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	399.00	0.00			
			TOTAL ANCILLARY	890,790.82	127,301.97
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	890,790.82	127,301.97

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	37,450.34	ADJUSTMENTS	0.00
COVERED CHARGES	33,466.34	CONTRACTUAL ALLOW	23,741.94
NON-COVERD CHARGES	3,984.00	TOTAL MEDICAID LIAB	9,724.40
		LESS: COB	9,700.40
		LESS: COPAYMENT	24.00
		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

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	492.34	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	95.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	808.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,412.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,189.00	478.00
EKG/ECG	493.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	17,545.00	324.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	104.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,328.00	3,182.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	33,466.34	3,984.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	33,466.34	3,984.00

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

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 07/01/15 THROUGH 06/30/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	108,128.29	ADJUSTMENTS	0.00
COVERED CHARGES	107,804.29	CONTRACTUAL ALLOW	86,460.37
NON-COVERD CHARGES	324.00	TOTAL MEDICAID LIAB	21,343.92
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	21,331.92
		TOTAL NUMBER OF CLAIMS	4

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 07/01/15 THROUGH 06/30/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	665.60	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	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	101,038.69	0.00
RADIOLOGY THERAPEUTIC	4,504.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,596.00	324.00			
			TOTAL ANCILLARY	107,804.29	324.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	107,804.29	324.00

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

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	07/01/15	THROUGH	06/30/16
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 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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,413,207.32	ADJUSTMENTS	75,003.80
COVERED CHARGES	5,088,452.32	CONTRACTUAL ALLOW	4,327,051.18
NON-COVERD CHARGES	1,324,755.00	TOTAL MEDICAID LIAB	761,401.14
		LESS: COB	5,858.18
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	755,542.96

TOTAL NUMBER OF ADMISSIONS 40

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	361		324	959,177.00		1,207,769.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	361		324	959,177.00		1,207,769.00
SPECIAL CARE SERVICES						
CCU	255		0	839,402.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	255		0	839,402.00		0.00
TOTAL ACCOMODATIONS	616		324	1,798,579.00		1,207,769.00

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

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

Run Date: 08/24/2017
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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 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	805,023.50	0.00	OTHER LAB	7,722.00	0.00
MED/SURG SUPPLY	271,956.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	657,485.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	76,988.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	32,173.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	118,136.03	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,403.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	96,085.45	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	867,078.00	116,986.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,626.00	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	119,810.03	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	93,708.06	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	87,174.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,712.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	23,274.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	923.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,993.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,323.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,280.00	0.00			
			TOTAL ANCILLARY	3,289,873.32	116,986.00
			TOTAL ACCOMODATIONS	1,798,579.00	1,207,769.00
			TOTAL CHARGES	5,088,452.32	1,324,755.00

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

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	09/01/15	THROUGH	08/31/16
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: 08/24/2017
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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 09/01/15 THROUGH 08/31/16
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

Run Date: 08/24/2017
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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	09/01/15	THROUGH	08/31/16
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: 08/24/2017
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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	09/01/15	THROUGH	08/31/16
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: 08/24/2017
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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	09/01/15	THROUGH	08/31/16
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: 08/24/2017
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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	09/01/15	THROUGH	08/31/16
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: 08/24/2017
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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	09/01/15	THROUGH	08/31/16
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: 08/24/2017
 Run Time: 04:09:15
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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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,864,848.24	ADJUSTMENTS	9,584.52
COVERED CHARGES	2,416,493.21	CONTRACTUAL ALLOW	2,109,030.84
NON-COVERD CHARGES	448,355.03	TOTAL MEDICAID LIAB	307,462.37
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	307,462.37

TOTAL NUMBER OF ADMISSIONS 11

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	585		0	593,775.00		397,302.28
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	585		0	593,775.00		397,302.28
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	585		0	593,775.00		397,302.28

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 01/01/16 THROUGH 12/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	345,649.75	0.00	OTHER LAB	11,586.50	0.00
MED/SURG SUPPLY	277,514.69	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	67,121.34	0.00	EDUCATION & TRAINING	8,150.52	0.00
RADIOLOGY-DIAGNOSTIC	17,777.65	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	50,750.83	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	31,023.17	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	165,782.08	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,794.31	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	784,067.47	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	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	1,831.60	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	25,682.70	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	8,330.77	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	54,824.64	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,358.70	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,516.24	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,326.16	301.92			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,379.92	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,822,718.21	51,052.75
			TOTAL ACCOMODATIONS	593,775.00	397,302.28
			TOTAL CHARGES	2,416,493.21	448,355.03

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

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 01/01/16 THROUGH 12/31/16
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: 08/24/2017
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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	01/01/16	THROUGH	12/31/16
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

Run Date: 08/24/2017
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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 01/01/16 THROUGH 12/31/16
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: 08/24/2017
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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	01/01/16	THROUGH	12/31/16
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	01/01/16	THROUGH	12/31/16
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	01/01/16	THROUGH	12/31/16
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: 08/24/2017
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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	01/01/16	THROUGH	12/31/16
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

EMORY JOHNS CREEK HOSPITAL
 6325 HOSPITAL PARKWAY
 JONES CREEK,GA 30097-5775

PROVIDER NUMBER 344886600A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,885,510.88	ADJUSTMENTS	486,312.00
COVERED CHARGES	7,399,444.11	CONTRACTUAL ALLOW	5,088,312.44
NON-COVERD CHARGES	486,066.77	TOTAL MEDICAID LIAB	2,311,131.67
		LESS: COB	101,407.85
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,209,723.82

TOTAL NUMBER OF ADMISSIONS 251

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,052		0	1,321,200.00		178,152.00
ROUTINE NURSERY	94		0	118,415.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,146		0	1,439,615.00		178,152.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	134		0	582,665.00		0.00
NICU	43		0	135,235.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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		0	717,900.00		0.00
TOTAL ACCOMODATIONS	1,323		0	2,157,515.00		178,152.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

EMORY JOHNS CREEK HOSPITAL
 6325 HOSPITAL PARKWAY
 JONES CREEK,GA 30097-5775

PROVIDER NUMBER
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	304,509.01	4,808.68	OTHER LAB	33,741.00	876.00
MED/SURG SUPPLY	258,630.00	8,948.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	821,815.38	26,729.66	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	93,040.00	1,508.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	374,161.00	2,199.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	142,563.84	1,412.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	25,448.00	146.00	MRI SERVICES	164,800.00	3,067.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	519,381.00	4,599.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	202,457.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	201,778.00	18,654.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	122,303.00	1,197.00	AMBULANCE	0.00	0.00
GI SERVICES	84,656.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	245,066.00	887.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	83,708.00	1,292.00	DRUG-SPECIFIC/HOME IV	0.00	20,630.00
LABORATORY PATHOLOGIC	52,707.02	0.00	INJECTABLE DRUGS	631,871.15	95,811.43
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	62,646.43	454.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	17,951.28	1,099.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	93,906.00	29,563.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	177,031.00	269.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	46,863.00
OTHER IMAGING SERVICE	38,612.00	9,409.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	55,062.00	8,755.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	61,544.00	16,908.00			
AUDIOLOGY	131.00	0.00			
CARDIOLOGY	333,048.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,473.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	37,889.00	1,830.00			
			TOTAL ANCILLARY	5,241,929.11	307,914.77
			TOTAL ACCOMODATIONS	2,157,515.00	178,152.00
			TOTAL CHARGES	7,399,444.11	486,066.77

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: 08/24/2017
 Run Time: 02:52:31
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EMORY JOHNS CREEK HOSPITAL
 6325 HOSPITAL PARKWAY
 JONES CREEK,GA 30097-5775

PROVIDER NUMBER
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2316046000025	12/12/15 - 12/14/15	03/28/16	0.00	9,401.00	0.00	4,135.27	0.00
615	2016046012948	02/05/16 - 02/08/16	02/22/16	0.00	3,181.00	0.00	0.00	0.00
615	2016081000004	03/08/16 - 03/15/16	03/28/16	0.00	12,440.00	0.00	0.00	0.00
615	2316264000018	07/06/16 - 07/08/16	10/10/16	0.00	12,440.00	0.00	3,341.42	0.00
615	2016273002330	12/28/15 - 12/29/15	10/03/16	0.00	9,401.00	0.00	0.00	0.00
TOTAL				0.00	46,863.00	0.00	7,476.69	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: 08/24/2017
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SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

EMORY JOHNS CREEK HOSPITAL
 6325 HOSPITAL PARKWAY
 JONES CREEK,GA 30097-5775

PROVIDER NUMBER
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	324,925.54	ADJUSTMENTS	0.00
COVERED CHARGES	321,859.54	CONTRACTUAL ALLOW	179,243.65
NON-COVERD CHARGES	3,066.00	TOTAL MEDICAID LIAB	142,615.89
		LESS: COB	142,615.89
		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	41		0	55,500.00		2,925.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	41		0	55,500.00		2,925.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	12		0	58,500.00		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	12		0	58,500.00		0.00
TOTAL ACCOMODATIONS	53		0	114,000.00		2,925.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

EMORY JOHNS CREEK HOSPITAL
 6325 HOSPITAL PARKWAY
 JONES CREEK,GA 30097-5775

PROVIDER NUMBER
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,083.52	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,216.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	30,520.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,745.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,480.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,972.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	292.00	0.00	MRI SERVICES	6,960.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,340.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	46,419.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,501.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	18,644.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,241.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,121.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	910.00	0.00	INJECTABLE DRUGS	13,524.98	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,159.02	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,425.02	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,765.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,439.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,299.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,345.00	141.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,458.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	207,859.54	141.00
			TOTAL ACCOMODATIONS	114,000.00	2,925.00
			TOTAL CHARGES	321,859.54	3,066.00

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: 08/24/2017
Run Time: 02:52:34
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EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,293,750.67	ADJUSTMENTS	29,710.40
COVERED CHARGES	1,851,800.06	CONTRACTUAL ALLOW	1,485,012.25
NON-COVERD CHARGES	441,950.61	TOTAL MEDICAID LIAB	366,787.81
		LESS: COB	795.13
		LESS: COPAYMENT	1,031.93
		REIMBURSEMENT	364,960.75
		ALL OTHER	329,564.08
		FEE SCHEDULE-LAB	27,037.09
		INJECTABLE DRUGS	8,359.58

TOTAL NUMBER OF CLAIMS 765

SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY JOHNS CREEK HOSPITAL
 6325 HOSPITAL PARKWAY
 JONES CREEK,GA 30097-5775

PROVIDER NUMBER
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,990.77	52,882.98	OTHER LAB	42,000.00	0.00
MED/SURG SUPPLY	38,972.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	77,269.00	1,558.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	338,488.00	91,927.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	392.00	4,499.02	FEE SCHEDULE LAB	256,204.20	11,774.00
EKG/ECG	16,206.00	292.00	MRI SERVICES	150,385.00	59,934.00
IV THERAPY	4,189.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	185,674.00	19,040.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	12,332.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,049.00	4,206.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	36,784.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	24,957.00	9,550.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	313,022.00	5,548.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	31,923.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	58,942.09	25,199.56
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	454.00	454.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	2,113.05	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,739.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	17,927.00	405.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,858.00	11,644.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	47,374.00	20,188.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	96.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	56,023.00	59,488.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	49,154.00	57,208.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	8,493.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	54,642.00	2,301.00			
			TOTAL ANCILLARY	1,851,800.06	441,950.61
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,851,800.06	441,950.61

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	135,477.38	ADJUSTMENTS	0.00
COVERED CHARGES	67,836.69	CONTRACTUAL ALLOW	27,260.81
NON-COVERD CHARGES	67,640.69	TOTAL MEDICAID LIAB	40,575.88
		LESS: COB	40,552.74
		LESS: COPAYMENT	23.14
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 31

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

EMORY JOHNS CREEK HOSPITAL
 6325 HOSPITAL PARKWAY
 JONES CREEK,GA 30097-5775

PROVIDER NUMBER
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	554.77	7,061.89	OTHER LAB	1,306.00	0.00
MED/SURG SUPPLY	1,676.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,550.00	1,444.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,199.00	42,904.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,051.58	426.00
EKG/ECG	584.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,374.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	324.00	214.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,522.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,492.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,173.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,284.34	1,979.80
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	3,387.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	9,048.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,965.00	1,176.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,781.00	0.00			
			TOTAL ANCILLARY	67,836.69	67,640.69
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	67,836.69	67,640.69

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: 08/24/2017
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EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/15 THROUGH 08/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	61,974.92	ADJUSTMENTS	0.00
COVERED CHARGES	55,796.04	CONTRACTUAL ALLOW	53,782.20
NON-COVERD CHARGES	6,178.88	TOTAL MEDICAID LIAB	2,013.84
		LESS: COB	0.00
		LESS: COPAYMENT	72.00
		REIMBURSEMENT	1,941.84
		TOTAL NUMBER OF CLAIMS	36

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY JOHNS CREEK HOSPITAL
 6325 HOSPITAL PARKWAY
 JONES CREEK,GA 30097-5775

PROVIDER NUMBER
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42.72	1,840.00	OTHER LAB	876.00	0.00
MED/SURG SUPPLY	66.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,084.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,861.00	1,729.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,100.00	68.00
EKG/ECG	146.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	213.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	24,772.00	337.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	895.32	807.88
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	740.00	1,397.00			
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	55,796.04	6,178.88
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	55,796.04	6,178.88

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
 6325 HOSPITAL PARKWAY
 JONES CREEK,GA 30097-5775

PROVIDER NUMBER
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/15 THROUGH 08/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,035.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	50.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,735.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	558.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,307.00	273.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	24.04	35.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,709.04	308.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,709.04	308.00

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

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/15	THROUGH	08/31/16
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: 08/24/2017
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/15	THROUGH	08/31/16
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **